Cigna Healthcare Value 3-Tier Prescription Drug List

Coverage as of January 1, 2026

For the State of California
Exclusive Provider Organization (EPO), LocalPlus (LocalPlus IN/LocalPlus), Open Access Plus (OAPIN/OAP), Preferred Provider Organization (PPO), SureFit

View your drug list online: **Cigna.com/druglist**
24/7 Customer Service: **800.Cigna24 (800.244.6224)**
View your coverage info online: myCigna® App or **myCigna.com®**

Last updated: 12/01/2025. This drug list is subject to change and all prior versions are no longer in effect.

View your drug list online, 24/7

This document was last updated on 12/01/2025.* Go online to see the most up-to-date information about the medications your plan covers.

- **Cigna.com/druglist.** Choose **Value 3 Tier** from the dropdown list. Then type in your medication name or view the full list.
- **myCigna App[1] or myCigna.com.** Log into your account and use the Price a Medication tool to see how your medication is covered.

Questions?

- **By phone:** Call the toll-free number on your Cigna Healthcare® ID card. We're here 24/7/365.
- **myCigna.com:** Click to Chat - Monday-Friday, 9:00 am-8:00 pm EST.

Information about this drug list

Frequently asked questions (FAQs)

Here are answers to questions you may have about your drug list and prescription medication coverage.

Q. How often is the drug list updated? How do I know if my medication coverage changed?
A. We review and update the drug list on a regular basis to make sure you have coverage for low-cost, safe and effective medications. We make changes for many reasons; for example, when a new medication comes out or is no longer available, or when a medication's price changes. These changes may include:

- **Moving a medication to a lower cost tier.** This can happen at any time during the year.
- **Moving a brand medication to a higher cost tier when a generic comes out.** This can happen at any time during the year.
- **Moving a medication to a higher cost tier and/or no longer covering a medication.** This typically happens twice a year on January I and July I.
- **Adding extra coverage rules (requirements) to a medication.** This typically happens twice a year on January I and July I.

When we make a change that affects your medication (for example, it'll cost more, won't be covered, and/or has an extra coverage requirement), we let you know before it happens. This way, you have time to talk with your doctor about your options. Only you and your doctor can decide what's best for your treatment.

Q. Why doesn't my plan cover certain medications?
A. To help lower your overall health care costs, your plan doesn't cover certain high-cost brand-name medications that have lower-cost alternatives that can treat the same condition. If your medication isn't covered and your doctor feels a different medication isn't right for you, your doctor's office can ask us to cover it through our review process.

There are also some medications and products that your plan won't cover for any reason because they're a "plan (or benefit) exclusion." This means the medication or product isn't on your drug list, and there's no option to ask us to cover it through our review process.

For example, your plan doesn't cover (or "excludes"):

- Prescription medications that treat allergies (ex. Allegra, Clarinex, Xyzal and generics) and heartburn/stomach acid conditions (ex. Nexium, Prilosec OTC and generics).
- Medications that treat lifestyle conditions, such as infertility, erectile dysfunction and smoking cessation.[2]
- Medications that the U.S. Food and Drug Administration (FDA) hasn't approved.

Q. How do you decide which medications to cover?
A. The Cigna Healthcare Prescription Drug List is developed with the help of the Cigna Healthcare Pharmacy and Therapeutics (P&T) Committee, which is a group of practicing doctors and pharmacists, most of whom work outside of Cigna Healthcare. The group meets regularly to review medical evidence and information provided by federal agencies, drug manufacturers, medical professional associations, national organizations and peer-reviewed journals about the safety and effectiveness of medications that are newly approved by the FDA and medications already on the market.

The Cigna Healthcare Health Plan Commercial Value Assessment Committee (HVAC) then looks at the results of the P&T Committee's clinical review, as well as the medication's overall value and other factors before adding it to, or removing it from, the drug list.

Information about this drug list

Frequently asked questions (FAQs) *(cont.)*

Q. Why do certain medications need approval before my plan will cover them?
A. The review process helps make sure you're getting coverage for the right medication, at the right cost, in the right amount and for the right situation.

Q. How do I know if a medication needs approval?
A. Check your drug list or log in to the myCigna App or **myCigna.com** and use the Price a Medication tool. If the medication has:

- **PA** (Prior Authorization) or **ST** (Step Therapy) next to it, it needs approval before your plan will cover it.
- **QL** (Quantity Limit) next to it, you may need approval depending on how much you're filling at one time.
- **AGE** (Age Requirement) next to it, you may need approval depending on your age.

Q. What types of medications typically need approval?
A. Medications that:

- May not be safe when you take them with other medications.
- Have lower-cost alternatives that work just as well at treating the same condition.
- Should only be used for certain health conditions.
- Are often used in the wrong way or are abused (taken more often than you should).

Q. What types of medications typically have quantity limits?
A. Medications that are often:

- Taken in a greater amount or used for a longer time than they should be.
- Used in the wrong way or are abused (taken more often than you should).

Q. What medications are part of Step Therapy?
A. They're typically high-cost medications that treat conditions such as:

- ADD/ADHD
- Allergies
- Bladder problems
- Breathing problems
- Depression
- High blood pressure
- High cholesterol
- Osteoporosis
- Pain
- Skin conditions
- Sleep disorders

Q. Why does my medication have an age requirement?
A. Not all medications are right for all ages. Some medications work best for people of a certain age or within a certain age range. As you get older, body changes can decrease the body's ability to break down or get rid of certain medications. This means that the medication may stay in your body longer. So, an older adult may need a lower dose of the medication or a different medication that's safer.

Q. How do I get approval (prior authorization) for my medication?
A. Ask your doctor's office to contact us to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at **cignaforhcp.com**.

We'll review the information your doctor sends us to make sure you meet the medication's coverage rules (requirements). We'll send you and your doctor a letter with our decision (approved/not approved) and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if we've made a decision. Or, you can log in to the myCigna App or **myCigna.com** to see where your medication is in the review process or to read about the decision we made.

Many times, we don't get all of the information we need from the doctor's office to approve coverage. If we don't approve your medication, your doctor can send us more information to review, using the same process as before. We're happy to review the request again. Depending on what your doctor sends this time, we may be able to approve coverage. Or you and your doctor can appeal the decision by sending us a request, in writing, that explains why we should cover the medication.

- **For non-urgent requests**, we'll let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances**, we'll let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. If we don't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication. Also, if you've already received approval for your plan to cover your medication, we can't limit or exclude coverage for that medication if your doctor continues to prescribe it to treat your condition (as long as the medication is appropriately prescribed and is safe and effective in treating your condition).

Q. My plan doesn't cover my medication. I need to take it because it's medically necessary for my treatment. How do I get approval (prior authorization) for my medication?
A. If your doctor feels that your medication is necessary for your treatment and an alternative isn't right for you, your doctor can ask us to consider approving coverage of your medication. Ask your doctor's office to contact us to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at **cignaforhcp.com**.

We'll review the information your doctor sends us to make sure you meet the medication's coverage rules (requirements). We'll send you and your doctor a letter with our decision (approved/not approved) and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if we've made a decision. Or, you can log in to the myCigna App or **myCigna.com** to see where your medication is in the review process or to read about the decision we made.

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- **For non-urgent requests**, we'll let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances**, we'll let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. **It's important to know that when medications are approved, it's typically for one year of coverage.** If your medication is approved for less time, it's because there's a clinical reason based on our coverage rules (requirements) for the medication and/or the reviewing doctor.

Q. My medication is part of the Step Therapy program. I don't want to try an alternative. How do I get approval (prior authorization) for my medication?
A. If you and your doctor feel an alternative medication won't work for you, your doctor can ask us to consider approving coverage of your current medication. Ask your doctor's office to contact us

to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at **cignaforhcp.com**.

We'll review the information your doctor sends us to make sure you meet the medication's coverage rules (requirements). We'll send you and your doctor a letter with our decision (approved/not approved) and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if we've made a decision. Or, you can log in to the myCigna App or **myCigna.com** to see where your medication is in the review process or to read about the decision we made.

Many times, we don't get all of the information we need from the doctor's office to approve coverage. If we don't approve your medication, your doctor can send us more information to review, using the same process as before. We're happy to review the request again. Depending on what your doctor sends this time, we may be able to approve coverage. Or you and your doctor can appeal the decision by sending us a request, in writing, that explains why we should cover the medication.

- **For non-urgent requests**, we'll let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances**, we'll let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. If we don't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication.

Your Step Therapy rights under California State law:

1. A carrier may impose prior authorization requirements on prescription drug benefits.
2. When there is more than one drug that is appropriate for the treatment of a medical condition, a carrier may require step therapy.
    a. In circumstances where an insured is changing policies, the new policy shall not require a repeat of step therapy when that insured is already being treated for a medical condition by a prescription drug provided that the drug is appropriately prescribed and is considered safe and effective. A new policy can impose a prior authorization requirement for the continued coverage of a prescription drug prescribed pursuant to step therapy imposed by the former policy. A new policy must also allow a prescribing provider to prescribe another drug covered by the new policy that is medically appropriate for the insured.
3. A carrier shall provide coverage for the medically necessary dosage and quantity of the drug prescribed for the treatment of a medical condition consistent with professionally recognized standards of practice.

Q. What happens if I try to fill a prescription that needs approval but I don't get approval ahead of time?

A. When your pharmacist tries to fill your prescription, they'll see that the medication needs our approval before it can be covered. Because you didn't get approval ahead of time, your plan won't cover its cost. If that happens, ask your doctor to contact us to start the coverage review process.

You can still fill it (without using your plan/insurance), but you'll pay its full price at the pharmacy counter. And, if you do this, your costs can't be applied to your annual deductible or out-of-pocket maximum.

Information about this drug list

Frequently asked questions (FAQs) *(cont.)*

Q. What happens if I try to fill a prescription that has a quantity limit?
A. Your pharmacist will only fill the amount your plan covers. If you want to fill more than what's allowed, your doctor's office can ask us to cover it through our review process.

Q. Are all of the medications on this drug list approved by the FDA?
A. Yes.

Q. Does my plan cover medications that the FDA recently approved?
A. We review all recently approved medications and products to see if they should be covered, and if so, at what cost-share (tier). These include, but are not limited to, medications, medical supplies and/or devices covered under standard pharmacy benefits. It can take up to six months from the date the FDA approved them for us to make a decision.

If your doctor wants you to use a recently approved medication, your doctor's office can ask us to cover it through our review process.

Q. What are preventive medications?
A. Preventive medications can help keep you from getting certain long-term health conditions such as asthma, depression, diabetes, heart attack, high blood pressure, high cholesterol, osteoporosis (a disease that causes bones to become weak), prenatal nutrient deficiency (when a pregnant person doesn't get enough of the nutrients they need) and stroke. They improve your changes of staying well and living longer.

Q. Which medications are covered under the health care reform law?
A. The Patient Protection and Affordable Care Act (PPACA), also known as health care reform, helps make health care and preventive care more affordable. PPACA requires health plans to cover the full cost of certain preventive medications and over-the-counter (OTC) products. This means you don't have to pay anything – not even a copay, coinsurance or deductible for these products.

To see a list of $0 medications, go to **Cigna.com/PDL** and click on the dropdown next to "Drug Lists for Employer Plans." Under the Preventive Drug Lists section, click on the link for the PPACA No Cost-Share Preventive Drug List.

Q. I see several medications on this drug list that can be used to treat my condition. Will my doctor write me a prescription for all of them?
A. No. Just because a medication is listed on your plan's drug list doesn't mean your doctor will write you a prescription for it. Your doctor will work with you to find the medication he or she feels is best for your specific treatment.

Q. How can I find out how much I'll pay for a specific medication?
A. When you and your doctor are thinking about the right medication for your treatment, knowing how much it costs, what lower-cost options are available, and which pharmacies have the best prices can help you avoid surprises. Log in to the myCigna App or **myCigna.com** and use the Price a Medication tool to see how much your medication costs before you get to the pharmacy counter – or even before you leave your doctor's office.[3]

Q. What's a cost-share?
A. It's the amount you pay out of your own pocket for a covered prescription and/or an eligible health care or related service. For some plans, the cost-share is a copay; for other plans, it's a coinsurance.

Q. How can I save money on my prescription medications?
A. You should think about using a medication that's covered on a lower tier, such as a generic or preferred brand medication, or by filling a 90-day supply (if your plan allows). Ask your doctor if one of these options may work for you.

Information about this drug list

Frequently asked questions (FAQs) *(cont.)*

Q. What's a generic medication?
A. A generic is the same as its brand-name version. It has the same active ingredient, strength and dosage form, treats the same condition(s), and works in the same way – and typically costs less.[4] Generics are typically sold under their chemical or scientific name, instead of the brand name.

Q. Do generics work the same as brand-name medications?
A. Yes. A generic medication works in the same way and provides the same clinical benefit as the brand-name medication.[4]

Q. What are the differences between generic and brand-name medications?
A. The generic and brand-name medication may[4]:

- Look different. For example, generics may have a different shape, size or color than their brand-name versions.
- Have a different flavor and/or different preservatives, come in different packaging and/or with different labeling and may expire at different times.

It's important to know that these differences don't affect how the generic works.

Q. What is a "biosimilar" medication?
A. A biosimilar is "highly similar" to its original biologic medication, which is also known as a reference product, that the FDA has already approved. Even though biosimilars aren't identical to the original medication, they're used to treat the same conditions, and provide the same clinical outcomes and treatment benefits. There are no clinical differences in how safe they are to use and how well they work. They also typically cost less.[5]

Q. How do I know which pharmacies are in my plan's network?
A. There are thousands of retail pharmacies in your plan's network. They include local pharmacies, grocery stores, retail chains and wholesale warehouse stores – all places where you may already shop. And some stores are open 24-hours. To find an in-network pharmacy near you, log in to the myCigna App or **myCigna.com**. Then click on the Prescriptions tab and choose "Find a Pharmacy" from the dropdown list.

Q. My pharmacy isn't in my plan's network. Can I continue to fill my prescriptions there?
A. To get the most from your plan coverage, you should use an in-network pharmacy. If your plan offers out-of-network coverage, you'll pay your out-of-network cost-share to fill a prescription there.

Q. Do I have to use home delivery to fill my prescription?
A. It depends on your plan. Some plans require you to fill maintenance medications through Express Scripts® Pharmacy and/or specialty medications through Accredo® Specialty Pharmacy for them to be covered.[6] Log in to the myCigna App or **myCigna.com**, or check your plan materials, to find out what your plan requires.

Q. Can I fill my prescriptions by mail?
A. Yes, as long as your plan offers home delivery.[6]

Fill maintenance medications through Express Scripts Pharmacy

Express Scripts Pharmacy is a convenient option when you're taking a medication on a regular basis to treat an ongoing health condition. It's simple and safe, and saves you trips to the pharmacy. To learn more, go to **Cigna.com/homedelivery**.

- Easily order, manage, track and pay for your medications on your phone or online.
- Get standard shipping at no extra cost.[7]
- Fill up to a 90-day supply at one time.
- Talk with a pharmacist, 24/7.
- Sign up for automatic refills or refill reminders so you don't miss a dose.[8]
- Use a payment plan (if you need it).

Here are two easy ways to get started:

1. **Online.** Log in to the myCigna App or **myCigna.com** and click on the Prescriptions tab. Choose My Medications from the dropdown list. Then click the button next to your medication name to move your prescription(s) from your retail pharmacy to home delivery. Or,
2. **By phone.**
   - Call your doctor's office. Ask them to send a 90-day prescription (with refills) to Express Scripts home delivery. Or,
   - Call Express Scripts Pharmacy at **800.835.3784**. They'll contact your doctor's office to get your prescription. Have your ID card, doctor's contact information and medication name(s) ready when you call.

Fill specialty medications through Accredo Specialty Pharmacy

If you're using a specialty medication, Accredo's team can help you manage your rare and/or complex medical condition. They'll also fill and ship your specialty medication to you, so you don't have to stand in line at the pharmacy. To learn more, go to **Cigna.com/specialty**.

- Talk with specially-trained pharmacists and nurses, 24/7.
- Get fast shipping at no extra cost.[7]
- Sign up for refills and reminders. Some refills can be done by text.[9]
- Get help paying for your medication (if you need it).
- Manage and track your medications online.

To get started, call **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST and Saturdays, 7:00 am–4:00 pm CST.

Q. I take a specialty medication to treat my multiple sclerosis. My plan requires me to fill my medication through Accredo. How do I get started?
A. Some plans allow one or more fills at a retail pharmacy before switching to Accredo. Check your plan materials to find out if your plan allows retail fills.

To get started using Accredo, call **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST and Saturdays, 7:00 am–4:00 pm CST. Be sure to call them about two weeks before your next refill so they have time to get a new prescription from your doctor's office.

Q. I take a specialty medication that can only be filled at certain pharmacies in the United States. How do I fill my prescription?
A. Talk with your doctor. He or she should be able to tell you which in-network pharmacies can fill your prescription. Once you find a pharmacy, ask your doctor to send them your prescription.

You may also be able to use Accredo to fill your prescription; they have access to most specialty medications.[6] Call Accredo at **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST or Saturdays, 7:00 am–4:00 pm CST, for more information.

Q. How do I fill my prescription?
A. First, you'll need to get a prescription from your doctor. Then, your doctor can either:

1. **Send it electronically** to the in-network retail pharmacy of your choice, Express Scripts home delivery or Accredo. Or
2. **Give you a paper prescription.** You can bring it to the in-network retail pharmacy of your choice or mail it to Express Scripts Pharmacy or Accredo.

Q. How can I get help with my specialty medication?
A. Managing a rare and/or complex medical condition isn't easy. Accredo's team of specialty-trained pharmacists and nurses can help. They'll also fill and ship your specialty medication to you, so you don't have to stand in line at the pharmacy.

Go to **Cigna.com/specialty** to learn more about Accredo or call **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST or Saturdays, 7:00 am–4:00 pm CST.

Information about this drug list

Frequently asked questions (FAQs) *(cont.)*

Q. Where can I find more information about my pharmacy benefits?
A. Use the online tools and resources on the myCigna App or **myCigna.com**. You can find out how much your medication costs (and what lower-cost options may be available), see which medications your plan covers, find an in-network pharmacy, ask a pharmacist a question, see your pharmacy claims and coverage details, and more. You can also manage your home delivery orders.

Q. How can I find out my cost-share for each tier of the drug list?
A. We put covered medications into tiers (or cost-share levels). Typically, the higher the tier, the higher the price you'll pay for the medication. Here are three places you can go to find out how much you'll pay for your medication based on the tier it's listed in, including the maximum cost-share amount allowed:

1. **Check your Cigna Healthcare ID card.** It lists your cost-share for Tier 1, Tier 2 and Tier 3 medications.
2. **Log in to the myCigna App or myCigna.com to view your pharmacy coverage information.** You can also use the Price a Medication tool to find out how much your medication may cost you at the different pharmacies in your plan's network.
3. **Check your Summary of Benefits** coverage document.

Q. What's the difference between medications covered under the pharmacy benefit and medical benefit?
A. Some medications are covered under the pharmacy benefit, some are covered under the medical benefit and others are covered under both benefits. Log in to the myCigna App or **myCigna.com**, or check your plan materials, to learn more about how your plan covers your medication.

- Medications that you fill at the pharmacy and take yourself are typically covered under the pharmacy benefit.
- Medications that are injected or infused and are given to you at a doctor's office, hospital, an infusion center or at home are typically covered under the medical benefit.

Why this matters: Which benefit the medication's covered under may affect how much it costs, if it needs approval from Cigna Healthcare before your plan will cover it and/or if you have to fill it through a certain pharmacy to be covered. Check your medical summary of benefits coverage to learn more about how your plan covers your medication.

Q. I take an oral cancer medication. How much will it cost me to fill?
A. On January 1, 2015, California passed a bill limiting the cost-share for oral chemotherapy medications. This means that if you have both your medical and pharmacy benefits through Cigna Healthcare, here's how certain oral cancer medications are covered:

- **For copay plans:** These medications will be covered at 100%, or no cost-share ($0) to you.
- **For high deductible health plans (HDHPs) that include a Health Savings Account (HSA) or qualified HDHPs:** You'll pay your plan deductible first. After that, these medications will be covered at 100%, or no cost-share ($0) to you. This is because of a federal HSA requirement.
- **For plans with a combined deductible [including Health Reimbursements Accounts (HRAs) with a combined deductible]:** You'll pay your plan deductible first. After that, these medications will be covered at 100%, or no cost-share ($0) to you.
- **For plans with a split deductible [including Health Reimbursements Accounts (HRAs) with a split deductible]:** These medications will be covered at 100%, or no cost-share ($0) to you.

Information about this drug list

Frequently asked questions (FAQs) *(cont.)*

Q. How are medications, devices and FDA-approved diabetic, contraceptive and federally-mandated products covered under the pharmacy benefit?
A. Here is how these products are covered under the pharmacy benefit:

- **Preventive care medications and products covered under the Patient Protection and Affordable Care Act (PPACA), also known as "health care reform:"**
  - **Contraceptives:** Covered at 100%, or no cost-share ($0) to you. Certain prescription contraceptives are available at their applicable cost-share.
  - **Tobacco cessation products:** Up to two (2) 90-day courses of treatment per plan year are covered at 100%, or no cost-share ($0) to you. Certain prescription tobacco cessation products are available at their applicable cost-share.
  - **Certain vitamins:** Covered at 100%, or no cost-share ($0) to you. All other prescription vitamins are available at their applicable cost-share and deductible (if applicable).
- **Certain over-the-counter (OTC) products:** If you have a prescription from your doctor, these are covered at 100%, or no cost-share ($0) to you. All other OTC products are excluded from coverage.
- **Oral fertility medications:** Covered at their applicable tier cost-share. For some plans, injectable fertility medications are covered under the medical benefit.
- **Generic preventive care medications:** Covered at 100%, or no cost-share ($0) to you before you meet your deductible. You'll pay your deductible and applicable cost-share to fill a preferred brand and/or non-preferred brand preventive care medication.
- **Diabetic supplies:** Covered at their applicable cost-share.
- **Growth Hormones:** Need approval from Cigna Healthcare before your plan will cover them (prior authorization). If approved, you'll pay your applicable tier cost-share to fill the medication.
- **Vaccines:** Vaccines are now covered under the pharmacy benefit. Not all plans cover vaccines in the same way. Log in to the myCigna App or **myCigna.com**, or check your plan materials, to find out how your specific plan covers them.
- **Compounded medications:** If the medication is more than $200, you'll need approval from Cigna Healthcare before your plan will cover them (prior authorization). If approved, you'll pay your applicable tier cost-share to fill the medication.

Words you may need to know

- **Brand name drug:** A drug that is marketed under a proprietary, trademark-protected name. A brand name drug is listed in this formulary in all CAPITAL letters.
- **Coinsurance:** A percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.
- **Copayment:** A fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.
- **Deductible:** The amount you pay for covered health care benefits that are subject to the deductible before your health insurer begins to pay. If your health insurance policy has a deductible, it may have either one deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.

Information about this drug list

Words you may need to know *(cont.)*

- **Drug tier:** A group of prescription drugs that correspond to a specified cost sharing tier in your health insurance policy. The drug tier in which a prescription drug is placed determines your portion of the cost for the drug.
- **Exception request:** A request for coverage of a non-formulary drug. If you, your designee, or your prescribing health care provider submits a request for coverage of a non-formulary drug, your insurer must cover the non-formulary drug when it is medically necessary for you to take the drug.
- **Exigent circumstances:** When you are suffering from a medical condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.
- **Formulary or prescription drug list:** The list of drugs that is covered by your health insurance policy under the prescription drug benefit of the policy.
- **Generic drug:** A drug that is the same as its brand name drug equivalent in dosage, strength, effect, how it is taken, quality, safety, and intended use. A generic drug is listed in this formulary in italicized lowercase letters.
- **Medically Necessary:** Health care benefits needed to diagnose, treat, or prevent a medical condition or its symptoms and that meet accepted standards of medicine. Health insurance usually does not cover health care benefits that are not medically necessary.
- **Non-formulary drug:** A prescription drug that is not listed on this formulary.
- **Out-of-pocket costs:** Your expenses for health care benefits that aren't reimbursed by your health insurance. Out-of-pocket costs include deductibles, copayments, and coinsurance for covered health care benefits, plus all costs for health care benefits that are not covered.
- **Prescribing provider:** A health care provider who can write a prescription for a drug to diagnose, treat, or prevent a medical condition.
- **Prescription:** An oral, written, or electronic order from a prescribing provider authorizing a prescription drug to be provided to a specific individual.
- **Prescription drug:** A drug that by law requires a prescription.
- **Prior Authorization:** A decision by your health insurer that a health care benefit is medically necessary for you. If a prescription drug is subject to prior authorization in this formulary, your prescribing provider must request approval from your health insurer to cover the drug before you fill your prescription. Your health insurer must grant a prior authorization request when it is medically necessary for you to take the drug.
- **Step Therapy:** A specific sequence in which prescription drugs for a particular medical condition must be tried. If a drug is subject to step therapy in this formulary, you may have to try one or more other drugs before your health insurance policy will cover that drug for your medical condition. If your prescribing provider submits a request for an exception to the step therapy requirement, your health insurer must grant the request when it is medically necessary for you to take the drug.
- **Quantity Limits:** For some medications, your plan will only cover up to a certain amount over a certain length of time. For example, 30mg per day for 30 days. Quantity limits help to make sure you're receiving coverage for the right medication, in the right amount, and for the right situation. Your plan will only cover a larger amount if your doctor requests and receives approval from Cigna Healthcare.
- **Age Requirements:** For certain medications, you must be within a specific age range for your plan to cover them. This is because some medications aren't considered clinically appropriate for individuals who aren't within that age range.

Information about this drug list

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare Value 3-Tier Prescription Drug List as of January 1, 2026. **The drug list is updated often**; so, not all of the medications your plan covers may be listed here. Also, your plan may not cover all of these medications. Log in to the myCigna App or **myCigna.com** to see which medications your plan covers.

Important: Your plan doesn't cover prescription medications that treat allergies (ex. Allegra®, Clarinex®, Xyzal® and generics) and heartburn/stomach acid conditions (ex. Nexium®, Prilosec OTC® and generics). Instead, you can buy them as over-the-counter (OTC) products at your local pharmacy or retail store without a prescription.

How to read this drug list

Medications are listed alphabetically by their generic and brand names within their therapeutic category and class.* You can also find your medication using the index at the end of this drug list.

- The generic version of a brand-name medication is listed in parentheses and all *lowercase italicized* letters next to the brand-name medication.
- If a generic equivalent for a brand-name medication is both available and covered, the generic will be listed separately from the brand-name medication in all *lowercase italicized* letters.
- If a generic equivalent for a brand-name medication isn't available on the market or isn't covered, the medication won't be listed separately by its generic version.
- If a generic medication is marketed under a proprietary, trademark-protected brand name, the brand-name medication will be listed after the generic version in parentheses and regular typeface with the first letter of each word capitalized. For example: *quinapril hcl* (Accupril).

Tiers

We put covered medications into tiers (or cost-share levels). Typically, the higher the tier, the higher the price you'll pay for the medication.

Tier 1	**Generics. These medications are covered at your plan's lowest cost-share.** Generics work in the same way and provide the same clinical benefits as their brand-name versions – and typically cost much less.[4]	**$**
Tier 2	**Preferred Brands.** These medications typically have one or more lower-cost generic that treats the same condition.	**$$**
Tier 3	**Non-Preferred Brands. These medications are covered at your plan's highest cost-share.** Non-preferred brands typically have a generic and/or preferred brand alternative(s) that treats the same condition.	**$$$**

* Medications are listed in the therapeutic category and class provided by First Databank.

Information about this drug list

How to read this drug list *(cont.)*

Letters (acronyms) in the Notes column
In this drug list, some medications have **letters (acronyms)** next to them in the Notes column. Here's what they mean.

PA	**Prior Authorization*** – This medication needs approval from Cigna Healthcare before your plan will cover it. Your doctor's office will have to send us information to review to make sure you meet the medication's coverage rules (requirements).
QL	**Quantity Limit*** – Your plan will only cover so much of this medication at one time. If your doctor wants you to fill more than what's allowed, your doctor's office can ask us to cover more.
ST	**Step Therapy*** – This is a high-cost medication that has a lower-cost alternative(s) that treats the same condition. Your plan won't cover this medication until you try at least one preferred medication first (typically a generic or preferred brand) and can show that it didn't work for you. If your doctor feels a preferred medication isn't right for you, your doctor's office can ask us to cover the higher-cost medication.
AGE	**Age Requirement*** – Your plan will only cover this medication if you're a certain age or within a certain age range. If you're not within the allowed age range and your doctor wants you to use the medication, your doctor's office can ask us to cover it.
SP	This is a **specialty medication**, which is used to treat a rare and/or complex medical condition. Some plans have extra coverage rules (requirements) for specialty medications. For example, some may only cover up to a 30-day supply and/or require you to fill it at a preferred specialty pharmacy to be covered.
HD	**Home Delivery Medications** – Some plans only cover certain maintenance medications if they're filled through home delivery with Express Scripts Pharmacy. Depending on your plan, you may be able to get coverage for one, two or three fills at an in-network retail pharmacy before you have to switch to home delivery.
PPACA	Health care reform under the **Patient Protection and Affordable Care Act (PPACA)** requires plans to cover the full cost of this preventive medication or product. This means you don't have to pay anything – not even a copay, coinsurance or deductible.
CSL	**Oral Cancer Medications Subject to Cost-Share Limits** – State law in California limits the cost-share (or amount you pay out-of-pocket) for certain oral chemotherapy medications.

* **Not all plans have extra coverage rules (requirements) on medications.** Log in to the myCigna App or myCigna.com, or check your plan materials, to see if yours does.

Information about this drug list

How to read this drug list *(cont.)*

Use the table below to understand how medications are covered on the Cigna Healthcare Value 3-Tier Prescription Drug List.*

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
butalbital/acetaminophen	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalb-aspirin-caffe 50-325-40	T1	QL (6 tabs/day)
butalbital-asa-caffeine cap (Fiorinal)	T1	QL (6 caps/day)
FIORINAL (*butalbital-aspirin-caffeine*)	T3	QL (6 caps/day)
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalb/acetaminophen/caffeine	T3	
butalb/acetaminophen/caffeine (Esgic)	T3	QL (6 caps/day)
butalb-acetamin-caff 50-300-40 (Fioricet)	T1	QL (6 caps/day)
butalb-acetamin-caff 50-325-40 (Esgic)	T1	QL (6 tabs/day)
ESGIC 50-325-40 MG TABLET (*butalbital-acetaminophen-caffe*)	T3	QL (6 tabs/day)
ESGIC CAPSULE (*zebutal*)	T3	QL (6 caps/day)
FIORICET (*phrenilin forte*)	T1	QL (6 caps/day)
ANALGESIC/ANTIPYRETICS, SALICYLATES		
choline salicyl/mag salicylate	T1	HD
diflunisal	T1	HD
ANTI-MIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR	T2	PA
AJOVY SYRINGE	T2	PA
almotriptan malate	T1	QL (12 tabs/30 days)
CAFERGOT (*ergotamine-caffeine*)	T3	QL (40 tabs/28 days)
dihydroergotamine 1 mg/ml amp	T1	QL (10 amps/30 days)
eletriptan hydrobromide	T1	QL (6 tabs/30 days)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
ergotamine tartrate/caffeine	T1	
ergotamine tartrate/caffeine (Cafergot)	T1	QL (40 tabs/28 days)

Therapeutic drug category and class describes the condition the medication is used to treat.

Coverage requirements and limits lets you know if your plan has extra requirements before it will cover the medication.

Drug tier gives you an idea of how much you may pay for a medication.

Prescription drug name is the name of the medication.

Medications are listed in **alphabetical order (A-Z)** within each column.

Brand name medications are in all **CAPITAL** letters.

Generic medications are in **lowercase italics**.

* This table is just an example. It may not show how these medications are currently covered on this drug list.

Information about this drug list

How to find your medication

First, look for the therapeutic category/class your medication is in using the alphabetical list below. Then, go to that page to see the covered medications available to treat the condition.

Information about this drug list

How to find your medication *(cont.)*

Information about this drug list

How to find your medication *(cont.)*

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
butalbital/acetaminophen	T1	
butalbital-acetaminophn 50-325	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalbital-aspirin-caffeine cp	T1	QL(6 CAPS/DAY)
butalbital-aspirin-caffeine tb	T1	QL(6 TABS/DAY)
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalb/acetaminophen/caffeine (Esgic)	T3	QL(6 CAPS/DAY)
butalb-acetamin-caff 50-300-40 (Fioricet)	T1	QL(6 CAPS/DAY)
butalb-acetamin-caff 50-325-40	T1	QL(6 TABS/DAY)
butalb-acetamin-caff 50-325-40 (Esgic)	T1	QL(6 CAPS/DAY)
ANALGESIC/ANTIPYRETICS, SALICYLATES		
diflunisal	T1	HD
ANTI-MIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR (3 PACK)	T2	PA
AJOVY SYRINGE	T2	PA
almotriptan malate	T1	QL (12 TABS/30 DAYS)
dihydroergotamine 1 mg/ml amp	T1	QL
eletriptan hydrobromide (Relpax)	T1	QL(6 TABS/30 DAYS)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
ergotamine tartrate/caffeine	T1	QL (40 TABS/28 DAYS)
frovatriptan succinate (Frova)	T1	QL(18 TABS/30 DAYS)
naratriptan hcl	T1	QL (9 TABS/30 DAYS)
NURTEC ODT	T2	PA QL (16 TABS/30 DAYS)
QULIPTA	T2	PA QL(1 TAB/DAY)
rizatriptan benzoate	T1	QL(12 TABS/30 DAYS)
rizatriptan benzoate (Maxalt Mlt)	T1	QL(12 TABS/30 DAYS)
rizatriptan benzoate (Maxalt)	T1	QL(12 TABS/30 DAYS)
sumatriptan	T1	QL(12 UNITS/30 DAYS)
sumatriptan 4 mg/0.5 ml cart (Imitrex)	T1	QL (4ML/30 DAYS)

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-MIGRAINE PREPARATIONS (*cont.*)		
sumatriptan 6 mg/0.5 ml vial	T1	QL (5ML/30 DAYS)
sumatriptan 6 mg/0.5ml autoinj (Imitrex)	T1	QL(4 MLS/30 DAYS)
sumatriptan succ 100 mg tablet (Imitrex)	T1	QL (9 TABS/30 DAYS)
sumatriptan succ 25 mg tablet (Imitrex)	T1	QL (9 TABS/30 DAYS)
sumatriptan succ 50 mg tablet (Imitrex)	T1	QL (9 TABS/30 DAYS)
sumatriptan succ/naproxen sod (Treximet)	T1	QL(18 TABS/30 DAYS)
UBRELVY	T2	PA QL (0.67 TABS/DAY)
ZAVZPRET	T2	PA QL(6 UNITS/30 DAYS)
zolmitriptan	T1	QL(6 TABS/30 DAYS)
zolmitriptan 2.5 mg tablet (Zomig)	T1	QL(6 TABS/30 DAYS)
zolmitriptan 5 mg tablet (Zomig)	T1	QL(6 TABS/30 DAYS)
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS		
diclofenac pot 50 mg tablet	T1	HD
diclofenac potassium	T1	HD
ketorolac 10 mg tablet	T1	QL(20 TABS/30 DAYS)
ketorolac 15 mg/ml syringe	T1	QL(8 MLS/DAY)
ketorolac 15 mg/ml vial	T1	QL(8 MLS/DAY)
ketorolac 30 mg/ml syringe	T1	QL(4 MLS/DAY)
ketorolac 30 mg/ml vial	T1	QL(4 MLS/DAY)
ketorolac 300 mg/10 ml vial	T1	
ketorolac 60 mg/2 ml syringe	T1	QL(4 MLS/DAY)
ketorolac 60 mg/2 ml vial	T1	QL(4 MLS/DAY)
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
acetamin-codein 300-30 mg/12.5	T1	
acetaminop-codeine 120-12 mg/5	T1	
acetaminophen-cod #2 tablet	T1	PA
acetaminophen-cod #3 tablet	T1	PA
acetaminophen-cod #4 tablet	T1	PA
hydrocodone/acetaminophen	T1	PA
hydrocodone/acetaminophen (Lortab)	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB *(hydrocodone/acetaminophen)*	T1	PA
NALOCET	T1	PA
oxycodone hcl/acetaminophen	T1	PA

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS (cont.)		
oxycodone hcl/acetaminophen (Percocet)	T1	PA
PRIMLEV	T1	PA
prolate 10-300 mg tablet	T1	PA
prolate 5-300 mg tablet	T1	PA
prolate 7.5-300 mg tablet	T1	PA
tramadol hcl/acetaminophen	T1	
OPIOID ANALGESIC AND NSAID COMBINATION		
hydrocodone/ibuprofen	T1	PA
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB (cont.)		
acetaminophen/caff/dihydrocod	T1	PA
TREZIX	T3	PA
OPIOID ANALGESICS		
ACTIQ (*fentanyl citrate*)	T3	PA
BELBUCA	T2	QL(2 FILMS/DAY)
buprenorphine (Butrans)	T1	QL(4 PATCHES/28 DAYS)
butorphanol tartrate	T1	PA QL(6 BOTTLES/30 DAYS)
BUTRANS (*buprenorphine)*	T3	QL(4 PATCHES/28 DAYS)
codeine sulfate	T1	PA
fentanyl	T1	PA
fentanyl citrate	T1	PA
FENTANYL CITRATE	T3	PA
fentanyl citrate (Actiq)	T1	PA
hydrocodone bitartrate	T1	PA
hydrocodone bitartrate (Hysingla Er)	T1	PA
hydromorphone hcl	T1	PA
hydromorphone hcl (Dilaudid)	T1	PA
HYSINGLA ER (*hydrocodone bitartrate*)	T2	PA
LAZANDA	T3	PA
meperidine hcl	T1	PA
methadone hcl	T1	PA
morphine sulfate	T1	PA
morphine sulfate (Ms Contin)	T1	PA
MS CONTIN (*morphine sulfate*)	T3	PA

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T3 – Typically Non-Preferred Brands

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
NUCYNTA	T3	PA
NUCYNTA ER	T3	PA
opium/belladonna alkaloids	T1	PA
OXAYDO	T3	PA
oxycodone hcl (ir) 10 mg, 20 mg tab	T1	PA
oxycodone hcl (ir) 5 mg, 15 mg, 30 mg tab (Roxicodone)	T1	PA
oxycodone hcl (ir) 5 mg cap	T1	PA
oxycodone hcl 100 mg/5 ml conc	T1	PA
oxycodone hcl 5 mg/5 ml cup	T1	PA
oxycodone hcl 5 mg/5 ml soln	T1	PA
OXYCODONE HCL ER	T1	PA
oxymorphone hcl	T1	PA
pentazocine hcl/naloxone hcl	T1	PA
ROXYBOND	T3	PA
tramadol hcl 50 mg tablet	T1	QL(8 TABS/DAY)
TRAMADOL HCL 75 MG TABLET	T3	QL(5 TABS/DAY)
tramadol hcl 100 mg tablet	T1	QL (4 TABS/DAY)
tramadol er 100 mg, 200 mg, 300 mg tablet	T1	QL (1 TAB/DAY)
TRAMADOL HCL ER 100 MG, 150 MG, 200 MG, 300 MG CAPSULE	T1	QL (1 CAP/DAY)
tramadol hcl er 100 mg, 200 mg, 300 mg tablet	T1	QL (1 TAB/DAY)
XTAMPZA ER	T2	PA
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
codeine/butalbital/asa/caffein	T1	PA
OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE		
butalbit/acetamin/caff/codeine	T1	PA
butalbit/acetamin/caff/codeine (Fioricet With Codeine)	T1	PA
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGES C		
carisoprodol/aspirin/codeine	T1	PA
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T3	
RIMSO-50	T2	

T1 – Typically Generics
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T3 – Typically Non-Preferred Brands

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List of Prescription Medications

ANESTHETICS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GENERAL ANESTHETICS, INHALANT		
desflurane	T1	
isoflurane	T1	
sevoflurane (Ultane)	T1	
SUPRANE	T3	
ULTANE (*sevoflurane*)	T3	
LOCAL ANESTHETICS		
lidocaine hcl	T1	
ANESTHETICS (Pain Relief and Inflammatory Disease)		
TOPICAL LOCAL ANESTHETICS		
lidocaine 5% ointment	T1	QL (145GM/30 DAYS)
lidocaine 5% patch (Lidoderm)	T1	
lidocaine 5% patch (Lidocan Ii)	T1	
lidocaine hcl	T3	
lidocaine/prilocaine	T1	
ZTLIDO	T2	
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
phenazopyridine hcl (Pyridium)	T1	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
cromolyn 100 mg/5 ml oral conc (Gastrocrom)	T1	
ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (*salsalate*)	T3	HD
salsalate (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (*penicillamine*)	T3	PA QL(6 CAPS/DAY) SP
penicillamine 250 mg capsule (Cuprimine)	T1	PA QL(6 CAPS/DAY) SP
penicillamine 250 mg tablet (Depen)	T1	PA QL(6 CAPS/DAY) SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
OTREXUP	T2	PA

T1 – Typically Generics
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AGE – Age Requirement
SP – Specialty Medication
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PPACA – No Cost-Share Preventive Medication
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List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
leflunomide (Arava)	T1	HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 10-20 MG STARTER 28 DAY	T2	PA QL(55 TABS/365 DAYS) SP HD
OTEZLA 10-20-30 MG START 28 DAY	T2	PA QL(55 TABS/365 DAYS) SP HD
OTEZLA 20 MG TABLET	T2	PA QL(2 TABS/DAY) SP HD
OTEZLA 30 MG TABLET	T2	PA QL (2 TABS/DAY) SP HD
OTEZLA XR 75 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
OTEZLA XR INITIATION PK 28 DAY	T2	PA QL(41 TABS/365 DAYS) SP HD
ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR		
ORENCIA	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
ORENCIA CLICKJECT	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
COLCHICINE		
colchicine 0.6 mg capsule (Mitigare)	T1	HD
colchicine 0.6 mg tablet (Colcrys)	T1	HD
MITIGARE (colchicine)	T2	HD
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
allopurinol 100 mg tablet (Zyloprim)	T1	HD
allopurinol 300 mg tablet		HD
febuxostat 40 mg tablet (Uloric)	T1	QL(1 TAB/DAY) HD
febuxostat 80 mg tablet (Uloric)	T1	HD
JANUS KINASE (JAK) INHIBITORS		
OLUMIANT	T3	PA QL(30 TABS/30 DAYS) SP HD
RINVOQ	T2	PA QL(1 TAB/DAY) SP HD
RINVOQ LQ	T2	PA QL(12 MLS/DAY) SP HD
XELJANZ 1 MG/ML SOLUTION	T2	PA QL(480 MLS/30 DAYS) SP HD
XELJANZ 10 MG TABLET	T2	PA QL (2 TABS/DAY) SP HD
XELJANZ 5 MG TABLET	T2	PA QL (2 TABS/DAY) SP HD
XELJANZ XR	T2	PA QL (1 TAB/DAY) SP HD
NSAIDS AND TOPICAL IRRITANT COUNTER-IRRITANT COMB.		
COMFORT PAC-IBUPROFEN	T3	
COMFORT PAC-MELOXICAM	T3	
COMFORT PAC-NAPROXEN	T3	

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List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS(COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (*diclofenac sodium/misoprostol)*	T3	ST HD
ARTHROTEC 75 (*diclofenac sodium/misoprostol*)	T3	ST HD
diclofenac sodium/misoprostol (Arthrotec 50)	T1	HD
diclofenac sodium/misoprostol (Arthrotec 75)	T1	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR- TYPE ANALGESICS		
ANAPROX DS (*naproxen sodium*)	T3	ST HD
DAYPRO (*oxaprozin*)	T3	ST HD
diclofenac sod dr 25, 50, 75 mg tab	T1	HD
diclofenac sod ec 25, 50, 75 mg tab	T1	HD
diclofenac sodium	T1	HD
EC-NAPROSYN (*naproxen*)	T3	ST HD
etodolac	T1	HD
etodolac (Lodine)	T1	HD
FELDENE (*piroxicam*)	T3	ST HD
fenoprofen 600 mg tablet (Nalfon)	T1	HD
flurbiprofen	T1	HD
ibuprofen	T1	HD
indomethacin 25 mg, 50 mg capsule	T1	HD
indomethacin 25 mg/5 ml susp (Indocin)	T1	HD
indomethacin 50 mg suppository (Indocin)	T1	HD
ketoprofen 50 mg, 75 mg capsule	T1	HD
ketoprofen er 200 mg capsule	T1	HD
LODINE (*etodolac*)	T3	ST HD
meclofenamate sodium	T1	HD
meloxicam (Mobic)	T1	HD
meloxicam 7.5 mg, 15 mg tablet	T1	HD
nabumetone (Relafen)	T1	HD
NALFON 600 MG TABLET *(fenoprofen calcium)*	T3	ST HD
NAPROSYN 500 MG TABLET *(naproxen)*	T3	ST HD
naproxen (Ec-naprosyn)	T1	HD
naproxen 250 mg, 375 mg tablet	T1	HD
naproxen 500 mg kit (Naprosyn)	T1	HD
naproxen 500 mg tablet (Naprosyn)	T1	HD

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T2 – Typically Preferred Brands
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List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE INHIBITOR- TYPE ANALGESICS *(cont.)*		
naproxen dr 375 mg tablet (Ec-Naprosyn)	T1	HD
naproxen dr 500 mg tablet (Ec-Naprosyn)	T1	HD
naproxen sodium	T1	HD
naproxen sodium (Anaprox Ds)	T1	HD
oxaprozin 600 mg caplet (Daypro)	T1	HD
oxaprozin 600 mg tablet (Daypro)	T1	HD
piroxicam	T1	HD
piroxicam (Feldene)	T1	HD
sulindac	T1	HD
tolmetin sodium	T1	HD
tolmetin sodium (Tolectin 600)	T1	HD
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
celecoxib 100 mg capsule (Celebrex)	T1	QL(2 CAPS/DAY) HD
celecoxib 200 mg capsule (Celebrex)	T1	QL(2 CAPS/DAY) HD
celecoxib 400 mg capsule (Celebrex)	T1	QL(1 CAP/DAY) HD
celecoxib 50 mg capsule (Celebrex)	T1	QL(2 CAPS/DAY) HD
URICOSURIC AGENTS		
probenecid	T1	HD
probenecid/colchicine	T1	HD
ANTI-ASTHMATICS (Asthma/COPD/Respiratory)		
5-LIPOXYGENASE INHIBITORS		
zileuton	T1	HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	HD
STRIVERDI RESPIMAT	T2	QL(1 INHALER/30 DAYS) HD
*tiotropium 18 mcg cap-inhaler (*Spiriva Handihaler*)*	T1	HD
*tiotropium 18 mcg cap-inhaler (*Spiriva Handihaler*)*	T1	QL(1 INHALER/30 DAYS) HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T2	QL(2 INHALERS/30 DAYS) HD
ipratropium bromide	T1	HD
BETA-ADRENERGIC AGENTS		
albuterol 2 mg/5 ml syrup cup	T1	HD
albuterol 8 mg/20 ml syrup cup	T1	HD
albuterol sulf 2 mg/5 ml syrup	T1	HD

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List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC AGENTS *(cont.)*		
albuterol sulfate 2 mg, 4 mg tab	T1	HD
albuterol sulfate er 4 mg, 8 mg tab	T1	HD
terbutaline sulfate	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
albuterol 100 mg/20 ml soln	T1	
albuterol 15 mg/3 ml solution	T1	
albuterol 2.5 mg/0.5 ml sol	T1	
albuterol 25 mg/5 ml solution	T1	
albuterol 5 mg/ml solution	T1	
albuterol 75 mg/15 ml soln	T1	
albuterol hfa 90 mcg inhaler	T1	QL(1 INHALER/30 DAYS)
albuterol sul 0.63 mg/3 ml sol	T1	
albuterol sul 1.25 mg/3 ml sol	T1	
albuterol sul 2.5 mg/3 ml soln	T1	
levalbuterol hcl (Xopenex Concentrate)	T1	
levalbuterol hcl (Xopenex)	T1	
XOPENEX *(levalbuterol hcl)*	T3	
XOPENEX CONCENTRATE *(levalbuterol hcl)*	T3	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
STRIVERDI RESPIMAT	T2	QL(1 INHALER/30 DAYS) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
arformoterol tartrate (Brovana)	T1	QL(4 MLS/DAY) HD
formoterol fumarate (Perforomist)	T1	QL(240 MLS/30 DAYS) HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA 62.5-25 MCG INH	T2	QL(1 INHALER/30 DAYS) HD
COMBIVENT RESPIMAT	T2	QL
ipratropium/albuterol sulfate	T2	HD
STIOLTO RESPIMAT	T2	QL(1 INHALER/30 DAYS) HD
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED		
AIRSUPRA	T2	QL(2 GMS/28 DAYS) HD
budesonide/formoterol fumarate (Symbicort)	T1	QL(1 INHALER/30 DAYS) HD
DULERA 100 MCG-5 MCG INHALER	T2	HD

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List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED *(cont.)*		
DULERA 100 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
DULERA 200 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
DULERA 50 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
fluticasone propion/salmeterol	T1	QL(1 INHALER/30 DAYS)
fluticasone-salmeterol 100-50 (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
fluticasone-salmeterol 250-50 (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
fluticasone-salmeterol 500-50 (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE INHALER	T2	QL(1 INHALER/30 DAYS)
TRELEGY ELLIPTA 100-62.5-25	T2	QL(1 BLISTER/30 DAYS)
TRELEGY ELLIPTA 200-62.5-25	T2	QL(1 BLISTER/30 DAYS)
GLUCOCORTICOIDS, ORALLY INHALED		
ALVESCO	T2	HD
ASMANEX HFA	T2	QL(1 INHALER/30 DAYS) HD
ASMANEX TWISTHALER	T2	QL
ASMANEX TWISTHALER 110 MCG #30	T2	QL(1 INHALER/30 DAYS) HD
ASMANEX TWISTHALER 220 MCG #14	T2	HD
ASMANEX TWISTHALER 220 MCG #30	T2	QL(1 INHALER/30 DAYS) HD
ASMANEX TWISTHALER 220 MCG #60	T2	QL(1 INHALER/30 DAYS) HD
ASMANEX TWISTHALER 220 MCG #120	T2	QL(1 INHALER/30 DAYS) HD
budesonide 0.25 mg/2 ml susp (Pulmicort)	T1	QL(4 MLS/DAY) HD
budesonide 0.5 mg/2 ml susp (Pulmicort)	T1	QL(4 MLS/DAY) HD
budesonide 1 mg/2 ml inh susp (Pulmicort)	T1	QL(2 MLS/DAY) HD
QVAR REDIHALER	T2	
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T2	PA SP HD
INTERLEUKIN-5 (IL-5) ANTAGONISTS, MAB		
NUCALA	T2	PA SP HD

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List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (*zafirlukast*)	T3	HD
montelukast sodium	T1	HD
montelukast sodium (Singulair)	T1	HD
zafirlukast (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn 20 mg/2 ml neb soln	T1	QL(480 MLS/30 DAYS) HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR	T2	PA SP HD
MUCOLYTICS		
acetylcysteine	T1	
PHOSPHODIESTERASE (PDE) INHIBITORS		
roflumilast 250 mcg tablet (Daliresp)	T1	QL(28 TABS/180 DAYS) HD
roflumilast 500 mcg tablet (Daliresp)	T1	QL(2 TABS/DAY) HD
XANTHINES		
THEO-24	T3	HD
theophylline anhydrous	T1	HD
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS, ANTIBIOTICS		
ciprofloxacin hcl	T1	
CORTISPORIN-TC	T3	
neomycin/polymyxin b/hydrocort	T1	
ofloxacin	T1	
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
ciprofloxacin hcl/dexameth	T1	
ciprofloxacin/hydrocortisone	T1	
OTOVEL	T3	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
neomycin/bacit/p-myx/hydrocort	T1	
neomycin/polymyxin b/dexametha (Maxitrol)	T1	
neomycin/polymyxin b/hydrocort	T1	
TOBRADEX	T3	

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List of Prescription Medications

ANTIBIOTICS (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS *(cont.)*		
TOBRADEX ST	T2	
tobramycin/dexamethasone	T1	
ZYLET	T3	
EYE SULFONAMIDES		
sulfacetamide sodium	T1	
sulfacetamide/prednisolone sp	T1	
OPHTHALMIC ANTIBIOTICS		
AZASITE	T2	
bacitracin	T1	
bacitracin/polymyxin b sulfate	T1	
BESIVANCE	T2	
ciprofloxacin hcl	T1	
erythromycin base	T1	
gatifloxacin	T1	
gentamicin sulfate	T1	
levofloxacin	T1	
moxifloxacin hcl	T1	
moxifloxacin hcl (Vigamox)	T1	
neomycin/bacitracin/polymyxinb	T1	
neomycin/polymyxn b/gramicidin	T1	
ofloxacin (*Ocuflox*)	T1	
polymyxin b sulf/trimethoprim	T1	
tobramycin 0.3% eye drop	T1	
ANTIBIOTICS (Infections)		
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (*sulfamethoxazole-trimethoprim*)	T3	
BACTRIM DS (*sulfamethoxazole-trimethoprim*)	T3	
sulfadiazine	T1	
sulfamethoxazole/trimethoprim	T1	
sulfamethoxazole/trimethoprim (Bactrim Ds)	T1	
sulfamethoxazole/trimethoprim (Bactrim)	T1	

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List of Prescription Medications

ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T3	PA SP
gentamicin sulfate	T1	
gentamicin sulfate/pf	T1	
KITABIS PAK	T3	PA QL(10 MLS/DAY) SP HD
neomycin sulfate	T1	
TOBI PODHALER	T2	PA QL(8 CAPS/DAY) SP HD
tobramycin 1,200 mg/30 ml vial	T1	
tobramycin 1.2 gm vial	T1	PA
tobramycin 1.2 gram/30 ml vial	T1	
tobramycin 20 mg/2 ml vial	T1	
tobramycin 300 mg/4 ml ampule (Bethkis)	T1	QL(8 MLS/DAY) SP HD
tobramycin 300 mg/5 ml ampule (Tobi)	T1	PA QL(10 MLS/DAY) SP HD
tobramycin 40 mg/ml vial	T1	
tobramycin 80 mg/2 ml vial	T1	
TOBRAMYCIN PAK 300 MG/5 ML	T3	PA QL(10 MLS/DAY) SP HD
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (*metronidazole*)	T3	
LIKMEZ	T3	PA
metronidazole 250 mg tablet	T1	
metronidazole 375 mg capsule (Flagyl)	T1	
metronidazole 500 mg tablet	T1	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
fosfomycin tromethamine	T1	
methenamine hippurate	T1	
methenamine mandelate	T1	
PRIMSOL	T3	
trimethoprim	T1	
ANTILEPROTICS		
dapsone 25 mg tablet	T1	
dapsone 100 mg tablet	T1	
THALOMID	T2	PA SP HD
ANTI-MYCOBACTERIUM AGENTS		
ethambutol hcl	T1	HD

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List of Prescription Medications

ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-MYCOBACTERIUM AGENTS *(cont.)*		
isoniazid	T1	HD
PASER	T3	HD
pyrazinamide	T1	HD
rifabutin (Mycobutin)	T1	HD
ANTI-TUBERCULAR ANTIBIOTICS		
cycloserine	T1	
PRETOMANID	T3	PA QL(1 TAB/DAY)
PRIFTIN	T3	
rifampin	T1	
SIRTURO	T3	SP
BETALACTAMS		
CAYSTON	T3	PA QL(3 MLS/DAY) SP HD
CEPHALOSPORIN ANTIBIOTICS - IST GENERATION		
cefadroxil	T1	
cephalexin	T1	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
cefaclor	T1	
cefprozil	T1	
cefuroxime axetil	T1	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
cefdinir	T1	
cefixime	T1	
cefpodoxime proxetil	T1	
ceftriaxone sodium	T1	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL *(clindamycin hcl)*	T3	
CLEOCIN PEDIATRIC *(clindamycin palmitate hcl)*	T3	
clindamycin hcl (Cleocin Hcl)	T1	
clindamycin palmitate hcl (Cleocin Pediatric)	T1	

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List of Prescription Medications

ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MACROLIDE ANTIBIOTICS		
azithromycin	T1	
azithromycin (Zithromax Tri-Pak)	T1	
azithromycin (Zithromax)	T1	
clarithromycin	T1	
DIFICID 200 MG TABLET *(fidaxomicin)*	T3	QL(28 TABS/28 DAYS)
DIFICID 40 MG/ML SUSPENSION	T3	QL(5 MLS/DAY)
ERYPED 200 *(erythromycin ethylsuccinate)*	T3	
ERY-TAB (*erythromycin base*)	T3	
erythromycin base	T1	
erythromycin base (Ery-Tab)	T1	
erythromycin ethylsuccinate	T1	
erythromycin ethylsuccinate (E.E.S. 200)	T1	
erythromycin ethylsuccinate (Eryped 200)	T1	
erythromycin ethylsuccinate (Eryped 400)	T1	
erythromycin stearate	T1	
fidaxomicin (Dificid)	T1	QL(28 TABS/28 DAYS)
ZITHROMAX *(azithromycin)*	T3	
ZITHROMAX TRI-PAK *(azithromycin)*	T3	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (*nitrofurantoin*)	T3	
MACROBID (*nitrofurantoin monohyd/m-cryst*)	T3	
nitrofurantoin 25 mg/5 ml susp (Furadantin)	T1	
nitrofurantoin mcr 100 mg cap	T1	
nitrofurantoin mcr 25 mg cap	T1	
nitrofurantoin mcr 50 mg cap	T1	
nitrofurantoin monohyd/m-cryst (Macrobid)	T1	
OXAZOLIDINONE ANTIBIOTICS		
linezolid (Zyvox)	T1	PA
SIVEXTRO	T3	PA
ZYVOX (*linezolid*)	T3	PA

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PENICILLIN ANTIBIOTICS		
amoxicillin	T1	
amoxicillin/potassium clav	T1	
amoxicillin/potassium clav (Augmentin Es-600)	T1	
amoxicillin/potassium clav (Augmentin Xr)	T1	
amoxicillin/potassium clav (Augmentin)	T1	
ampicillin trihydrate	T1	
dicloxacillin sodium	T1	
MOXATAG	T3	
penicillin v potassium	T1	
PLEUROMUTILIN DERIVATIVES		
XENLETA	T3	PA QL(10 TABS/30 DAYS)
QUINOLONE ANTIBIOTICS		
BAXDELA	T3	PA
CIPRO (*ciprofloxacin hcl*)	T3	
CIPRO (*ciprofloxacin*)	T3	
ciprofloxacin (Cipro)	T1	
ciprofloxacin hcl	T1	
ciprofloxacin hcl (Cipro)	T1	
FACTIVE	T3	
levofloxacin	T1	
moxifloxacin hcl	T1	
ofloxacin	T1	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL(12 TABS/30 DAYS)
XIFAXAN 200 MG TABLET	T2	QL(9 TABS/30 DAYS)
XIFAXAN 550 MG TABLET	T2	QL(42 TABS/30 DAYS)
TETRACYCLINE ANTIBIOTICS		
coremino er 135 mg tablet	T1	
coremino er 45 mg tablet	T1	QL(1 TAB/DAY)
coremino er 90 mg tablet	T1	
demeclocycline hcl	T1	
doxycycline 50 mg tablet (Targadox)	T1	
doxycycline hyclate	T1	

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TETRACYCLINE ANTIBIOTICS *(cont.)*		
doxycycline hyclate 100 mg cap	T1	
doxycycline hyclate 100 mg tab (Lymepak)	T1	
doxycycline hyclate 150 mg tab (Acticlate)	T1	
doxycycline hyclate 50 mg cap	T1	
doxycycline hyclate 75 mg tab (Acticlate)	T1	
doxycycline monohydrate	T1	
minocycline er 105 mg tablet	T1	
minocycline er 115 mg tablet (Solodyn)	T1	
minocycline er 135 mg tablet	T1	
minocycline er 45 mg tablet	T1	QL (1 TAB/DAY)
minocycline er 55 mg tablet	T1	
minocycline er 65 mg tablet	T1	
minocycline er 80 mg tablet	T1	
minocycline er 90 mg tablet	T1	
minocycline hcl	T1	
NUZYRA	T3	PA QL (30 TABLETS/28 DAYS) SP
tetracycline 250 mg capsule	T1	
tetracycline 500 mg capsule	T1	
VAGINAL ANTIBIOTICS		
clindamycin phosphate (Cleocin)	T1	
metronidazole	T1	
metronidazole vaginal 0.75% gl	T1	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
vancomycin 25 mg/ml oral soln	T1	
vancomycin 250 mg/5ml oral sol (Firvanq)	T1	
vancomycin 50 mg/ml oral soln (Firvanq)	T1	
vancomycin hcl 125 mg capsule (Vancocin Hcl)	T1	
vancomycin hcl 250 mg capsule (Vancocin Hcl)	T1	
ANTIBIOTICS (Skin Conditions)		
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
NEO-SYNALAR	T3	

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ANTIBIOTICS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTIBIOTICS		
BENZAMYCIN (*erythromycin-benzoyl peroxide*)	T3	
CENTANY	T3	
CENTANY AT	T3	
CLEOCIN T (*clindamycin phosphate*)	T3	
clindamycin phosphate	T1	
clindamycin phosphate (Cleocin T)	T1	
clindamycin phosphate (Clindagel)	T1	
clindamycin phosphate (Evoclin)	T1	
erythromycin base in ethanol	T1	
erythromycin/benzoyl peroxide (Benzamycin)	T1	
EVOCLIN (*clindamycin phosphate*)	T3	
gentamicin sulfate	T1	
mupirocin 2% ointment	T1	
XEPI	T3	
TOPICAL SULFONAMIDES		
mafenide acetate	T1	
PLEXION	T3	
SILVADENE (*silver sulfadiazine*)	T3	
silver sulfadiazine (Silvadene)	T1	
sulfacetamide sodium/sulfur	T1	
SULFAMYLON	T3	
ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)		
ANTI-COAGULANTS, COUMARIN TYPE		
warfarin sodium	T1	HD
CITRATES AS ANTI-COAGULANTS		
ACD SOLUTION A	T3	
ACD-A SOLUTION	T2	
ANTICOAGULANT SODIUM CITRATE	T3	
CITRATE PHOSPHATE DEXTROSE	T1	
SODIUM CITRATE	T1	
DIRECT FACTOR XA INHIBITORS		
ELIQUIS	T2	

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ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIRECT FACTOR XA INHIBITORS *(cont.)*		
ELIQUIS SPRINKLE	T2	
rivaroxaban (Xarelto)	T1	
XARELTO	T2	
XARELTO (*rivaroxaban*)	T2	
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA 10 MG/0.8 ML SYRINGE (*fondaparinux sodium*)	T3	QL(0.8 ML/DAY) SP
ARIXTRA 2.5 MG/0.5 ML SYRINGE (*fondaparinux sodium*)	T3	QL(0.5 ML/DAY) SP
ARIXTRA 5 MG/0.4 ML SYRINGE (*fondaparinux sodium*)	T3	QL(0.4 ML/DAY) SP
ARIXTRA 7.5 MG/0.6 ML SYRINGE (*fondaparinux sodium*)	T3	QL(0.6 ML/DAY) SP
enoxaparin 100 mg/ml syringe (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
enoxaparin 120 mg/0.8 ml syr (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
enoxaparin 150 mg/ml syringe (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
enoxaparin 30 mg/0.3 ml syr (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
enoxaparin 300 mg/3 ml vial (Lovenox)	T1	QL(1 VIAL/DAY) SP
enoxaparin 40 mg/0.4 ml syr (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
enoxaparin 60 mg/0.6 ml syr (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
enoxaparin 80 mg/0.8 ml syr (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
*fondaparinux 10 mg/0.8 ml syr (*Arixtra*)*	T1	QL(0.8 ML/DAY) SP
*fondaparinux 2.5 mg/0.5 ml syr (*Arixtra*)*	T1	QL(0.5 ML/DAY) SP
*fondaparinux 5 mg/0.4 ml syr (*Arixtra*)*	T1	QL(0.4 ML/DAY) SP
*fondaparinux 7.5 mg/0.6 ml syr (*Arixtra*)*	T1	QL(0.6 ML/DAY) SP
FRAGMIN 10,000 UNIT/4 ML VIAL	T2	QL(1 VIAL/DAY) SP
FRAGMIN 10,000 UNIT/ML SYRINGE	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 12,500 UNIT/0.5 ML SYR	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 15,000 UNIT/0.6 ML SYR	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 18,000 UNIT/0.72 ML	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 2,500 UNIT/0.2 ML SYR	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 5,000 UNIT/0.2 ML SYR	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 7,500 UNIT/0.3 ML SYR	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 95,000 UNIT/3.8 ML VL	T2	QL(1 VIAL/DAY) SP
heparin 10,000 unit/10 ml vial	T1	
heparin 2,000 unit/2 ml vial	T1	
heparin 30,000 unit/30 ml vial	T1	

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List of Prescription Medications

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEPARIN AND RELATED PREPARATIONS *(cont.)*		
heparin 40,000 unit/4 ml vial	T1	
heparin 5,000 unit/ml carpujct	T1	
heparin 50,000 unit/10 ml vial	T1	
heparin 50,000 unit/5 ml vial	T1	
heparin sod 1,000 unit/ml vial	T1	
heparin sod 10,000 unit/ml vl	T1	
heparin sod 20,000 unit/ml vl	T1	
heparin sod 5,000 unit/0.5 ml	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T3	
heparin sod 5,000 unit/ml syrg	T1	
HEPARIN SOD 5,000 UNIT/ML SYRG	T3	
heparin sod 5,000 unit/ml vial	T1	
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE		
dabigatran etexilate mesylate (Pradaxa)	T1	HD
ANTIDOTES (Gastrointestinal/Heartburn)		
MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
MOVANTIK	T2	PA
RELISTOR 12 MG/0.6 ML SYRINGE	T3	PA
RELISTOR 12 MG/0.6 ML VIAL	T3	PA
RELISTOR 8 MG/0.4 ML SYRINGE	T3	PA
SYMPROIC	T2	PA
ANTIDOTES (Substance Abuse)		
OPIOID ANTAGONISTS		
KLOXXADO	T2	QL(2 UNITS/30 DAYS)
naloxone 0.4 mg/ml carpuject	T1	
naloxone 0.4 mg/ml syringe	T1	
naloxone 0.4 mg/ml vial	T1	
naloxone 2 mg/2 ml syringe	T1	
naloxone 4 mg/10 ml vial	T1	
naloxone hcl 4 mg nasal spray (Narcan)	T1	QL(2 UNITS/30 DAYS)
naltrexone hcl	T1	QL(180 TABS/30 DAYS)

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ANTIDOTES (Substance Abuse) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANTAGONISTS *(cont.)*		
NARCAN (*naloxone hcl*)	T2	QL(2 UNITS/30 DAYS)
OPVEE	T3	QL(2 UNITS/30 DAYS)
REXTOVY	T2	QL(2 UNITS/30 DAYS)
ZIMHI	T3	QL(2 SYRINGES/30 DAYS)
ANTI-FUNGALS (Eye Conditions)		
OPHTHALMIC ANTI-FUNGAL AGENTS		
NATACYN	T3	
ANTI-FUNGALS (Feminine Products)		
VAGINAL ANTI-FUNGALS		
GYNAZOLE 1	T1	
miconazole nitrate	T1	
terconazole	T1	
ANTI-FUNGALS (Infections)		
ANTI-FUNGAL AGENTS		
ANCOBON (*flucytosine*)	T3	
clotrimazole	T1	
CRESEMBA	T3	PA
fluconazole	T1	
fluconazole (Diflucan)	T1	
flucytosine (Ancobon)	T1	
itraconazole	T1	
itraconazole (Sporanox)	T1	
ketoconazole	T1	
NOXAFIL 300 MG POWDERMIX SUSP	T3	
ORAVIG	T3	
posaconazole	T1	
posaconazole (Noxafil)	T1	
terbinafine hcl	T1	
VFEND (*voriconazole*)	T3	PA
VIVJOA	T3	PA SP
voriconazole (Vfend)	T1	PA

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ANTI-FUNGALS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-FUNGAL ANTIBIOTICS		
griseofulvin ultra 125 mg tab	T1	
griseofulvin ultra 165 mg tab	T1	QL(4 TABS/DAY)
griseofulvin ultra 250 mg tab	T1	
griseofulvin, microsize	T1	
nystatin	T1	
ANTI-FUNGALS (Skin Conditions)		
TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
clotrimazole/betamethasone dip	T1	
TOPICAL ANTI-FUNGALS		
ciclodan 0.77% cream (Loprox)	T1	
CICLODAN 0.77% CREAM KIT	T3	
CICLODAN 8% KIT	T3	
ciclodan 8% solution	T1	
ciclopirox	T1	
ciclopirox olamine (Loprox)	T1	
ciclopirox/urea/camph/men/euc	T1	
econazole nitrate 1% cream	T1	
ECOZA	T3	
EXODERM	T1	
ketoconazole	T1	
*ketoconazole (*Extina*)*	T1	
LOPROX 0.77% SUSPENSION KIT	T3	
LOPROX 0.77% TOPICAL SUSP (*ciclopirox olamine*)	T3	
LULICONAZOLE	T1	
naftifine hcl	T1	
naftifine hcl (Naftin)	T1	
NAFTIN (*naftifine hcl*)	T3	
nystatin	T1	
nystatin/triamcinolone acet	T1	
ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
phenylephrine hcl/prometh hcl	T1	

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List of Prescription Medications

ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T3	
ANTIHISTAMINES (Allergy/Nasal Sprays)		
ANTIHISTAMINES - 1ST GENERATION		
carbinoxamine 4 mg/5 ml liquid	T1	
carbinoxamine maleate	T1	
carbinoxamine maleate 4 mg tab	T1	
clemastine fum 2.68 mg tablet	T1	
clemastine fumarate	T1	
cyproheptadine hcl	T1	
hydroxyzine hcl	T1	
hydroxyzine pamoate	T1	
hydroxyzine pamoate (Vistaril)	T1	
promethazine hcl	T1	
VISTARIL (*hydroxyzine pamoate*)	T3	
ANTIHISTAMINES - 2ND GENERATION		
cetirizine hcl	T1	HD
desloratadine 2.5 mg odt	T1	QL (1 TAB/DAY) HD
desloratadine 5 mg odt	T1	HD
desloratadine 5 mg tablet	T1	HD
levocetirizine dihydrochloride	T1	HD
ANTIHISTAMINES (Eye Conditions)		
EYE ANTIHISTAMINES		
azelastine hcl 0.05% drops	T1	
bepotastine besilate	T1	
epinastine hcl	T1	
olopatadine hcl 0.1% eye drops	T1	
olopatadine hcl 0.2% eye drop	T1	
ANTI-HYPERGLYCEMICS (Diabetes)		
ANTIHYPERGLY, INCRETIN MIMETIC (GLP-1 RECEP.AGONIST)		
BYDUREON BCISE	T2	PA QL(4 MLS/28 DAYS)
exenatide	T1	PA QL(3 MLS/30 DAYS)
liraglutide 2-pak 18 mg/3 ml (Victoza 2-Pak)	T1	PA QL(3 PENS/30 DAYS)

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ANTI-HYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS		
liraglutide 2-pak 18 mg/3 ml (Victoza 3-Pak)	T1	PA QL(3 PENS/30 DAYS)
liraglutide 3-pak 18 mg/3 ml (Victoza 2-Pak)	T1	PA QL(3 PENS/30 DAYS)
liraglutide 3-pak 18 mg/3 ml (Victoza 3-Pak)	T1	PA QL(3 PENS/30 DAYS)
OZEMPIC	T2	PA QL(3 MLS/28 DAYS)
RYBELSUS	T2	PA QL(1 TAB/DAY)
TRULICITY	T2	PA QL(2 MLS/28 DAYS)
ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-1 RECEPT.AGONIST		
SOLIQUA 100-33	T2	
ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD
ANTI-HYPERGLYCEMIC - INCRETIN MIMETICS COMBINATION		
MOUNJARO 10 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
MOUNJARO 12.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
MOUNJARO 15 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
MOUNJARO 2.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/365 DAYS)
MOUNJARO 5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
MOUNJARO 7.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose (Precose)	T1	HD
miglitol	T1	HD
PRECOSE (*acarbose*)	T3	HD
ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 120	T2	HD
SYMLINPEN 60	T2	
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE		
metformin hcl	T1	HD
metformin hcl 1,000 mg tablet	T1	HD
metformin hcl 500 mg tablet	T1	HD
metformin hcl 500 mg/5 ml cup (Riomet)	T1	HD
metformin hcl 500 mg/5 ml soln (Riomet)	T1	HD
metformin hcl 750 mg tablet	T1	HD
metformin hcl 850 mg tablet	T1	HD
RIOMET (*metformin hcl*)	T3	HD

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	ST QL(1 TAB/DAY) HD
saxagliptin hcl (Onglyza)	T1	QL(1 TAB/DAY) HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
glimepiride 1 mg tablet	T1	HD
glimepiride 2 mg tablet	T1	HD
GLIMEPIRIDE 3 MG TABLET	T3	HD
glimepiride 4 mg tablet	T1	HD
*glipizide (*Glucotrol XL*)*	T1	HD
glipizide 10 mg tablet	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
glipizide 5 mg tablet	T1	HD
GLUCOTROL XL (*glipizide*)	T3	HD
glyburide	T1	HD
glyburide,micronized	T1	HD
glyburide,micronized (Glynase)	T1	HD
GLYNASE *(glyburide,micronized)*	T3	HD
nateglinide	T1	HD
repaglinide	T1	HD
ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	ST QL(1 TAB/DAY) HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (*pioglitazone hcl/metformin hcl*)	T3	HD
pioglitazone hcl/metformin hcl	T1	HD
pioglitazone hcl/metformin hcl (Actoplus Met)	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (*pioglitazone-glimepiride*)	T3	HD
pioglitazone hcl/glimepiride (Duetact)	T1	HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T2	ST QL(2 TABS/DAY) HD
JANUMET XR 100-1, 000 MG TABLET	T2	ST QL(1 TAB/DAY) HD
JANUMET XR 50-1, 000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
JANUMET XR 50-500 MG TABLET	T2	ST QL(1 TAB/DAY) HD
linagliptin/metformin hcl	T1	QL(2 TABS/DAY) HD

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ANTI-HYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS. (cont.)		
saxagliptin-metformin er 5-500 (Kombiglyze Xr)	T1	QL(1 TAB/DAY) HD
saxagliptin-metformn er 5-1000 (Kombiglyze Xr)	T1	QL(1 TAB/DAY) HD
saxagliptn-metform er 2.5-1000 (Kombiglyze Xr)	T1	QL(2 TABS/DAY) HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
glipizide/metformin hcl	T1	HD
glyburide/metformin hcl	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
pioglitazone hcl (Actos)	T1	HD
ANTI-HYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
mifepristone 300 mg tablet (Korlym)	T1	PA SP
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SYNJARDY	T2	ST QL(2 TABS/DAY) HD
SYNJARDY XR 10-1, 000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
SYNJARDY XR 12.5-1, 000 MG TAB	T2	ST QL(2 TABS/DAY) HD
SYNJARDY XR 25-1,000 MG TABLET	T2	ST QL(1 TAB/DAY) HD
SYNJARDY XR 5-1,000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
XIGDUO XR 10 MG-1,000 MG TAB	T2	ST QL(1 TAB/DAY) HD
XIGDUO XR 10 MG-500 MG TABLET	T2	ST QL(1 TAB/DAY) HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	ST QL(2 TABS/DAY) HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
XIGDUO XR 5 MG-500 MG TABLET	T2	ST QL(1 TAB/DAY) HD
ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH		
FARXIGA	T2	ST QL(1 TAB/DAY)
JARDIANCE	T2	ST QL(1 TAB/DAY) HD
ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIJARDY XR 10-5-1,000 MG TAB	T2	ST QL(1 TAB/DAY) HD
TRIJARDY XR 12.5-2.5-1,000 MG	T2	ST QL(2 TABS/DAY) HD
TRIJARDY XR 25-5-1,000 MG TAB	T2	ST QL(1 TAB/DAY) HD
TRIJARDY XR 5-2.5-1,000 MG TAB	T2	ST QL(2 TABS/DAY) HD
INSULINS		
BASAGLAR KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
BASAGLAR TEMPO PEN U-100	T2	QL(1.5 MLS/DAY) HD
HUMALOG	T2	QL(1.5 MLS/DAY) HD
HUMALOG JUNIOR KWIKPEN	T2	QL(1.5 MLS/DAY) HD

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ANTI-HYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INSULINS (cont.)		
HUMALOG KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
HUMALOG KWIKPEN U-200	T2	QL(1 ML/DAY) HD
HUMALOG MIX 50-50 KWIKPEN	T2	QL(2 MLS/DAY) HD
HUMALOG MIX 75-25	T2	QL(2 MLS/DAY) HD
HUMALOG MIX 75-25 KWIKPEN	T2	QL(2 MLS/DAY) HD
HUMALOG TEMPO PEN U-100	T2	QL(1.5 MLS/DAY) HD
HUMULIN 70/30 KWIKPEN	T2	QL(2 MLS/DAY) HD
HUMULIN 70-30	T2	QL(2 MLS/DAY) HD
HUMULIN N	T2	QL(1.5 MLS/DAY) HD
HUMULIN N KWIKPEN	T2	QL(1.5 MLS/DAY) HD
HUMULIN R	T2	QL(1.5 MLS/DAY) HD
HUMULIN R U-500	T2	QL(1 ML/DAY) HD
HUMULIN R U-500 KWIKPEN	T2	QL(1 ML/DAY) HD
INSULIN LISPRO	T2	QL(1.5 MLS/DAY) HD
INSULIN LISPRO JUNIOR KWIKPEN	T2	QL(1.5 MLS/DAY) HD
INSULIN LISPRO KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
INSULIN LISPRO PROTAMINE MIX	T2	QL(2 MLS/DAY) HD
LYUMJEV	T2	QL(1.5 MLS/DAY) HD
LYUMJEV KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
LYUMJEV KWIKPEN U-200	T2	QL(1 ML/DAY) HD
LYUMJEV TEMPO PEN U-100	T2	QL(1.5 MLS/DAY) HD
REZVOGLAR KWIKPEN	T2	QL(1.5 MLS/DAY) HD
TRESIBA	T2	QL(1.5 MLS/DAY) HD
TRESIBA FLEXTOUCH U-100	T2	QL(1.5 MLS/DAY) HD
TRESIBA FLEXTOUCH U-200	T2	QL(0.9 MLS/DAY) HD
ANTI-INFECTIVES/MISCELLANEOUS (Feminine Products)		
VAGINAL ANTISEPTICS		
acetic acid/oxyquinoline (Relagard)	T1	
RELAGARD (*acetic acid/oxyquinoline*)	T3	
TRIMO-SAN	T3	
ANTI-INFECTIVES/MISCELLANEOUS (Infections)		
2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL		
tinidazole	T1	

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ANTI-INFECTIVES/MISCELLANEOUS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTHELMINTICS		
albendazole	T1	
BILTRICIDE (*praziquantel*)	T3	
EMVERM	T1	
ivermectin 3 mg tablet (Stromectol)	T1	PA
ivermectin 6 mg tablet	T1	PA
praziquantel (Biltricide)	T1	
STROMECTOL (*ivermectin*)	T3	PA
ANTI-MALARIAL DRUGS		
atovaquone/proguanil hcl (Malarone)	T1	
chloroquine phosphate	T1	
COARTEM	T3	PA QL(24 TABS/30 DAYS)
hydroxychloroquine sulfate	T1	
hydroxychloroquine sulfate (Plaquenil)	T1	
KRINTAFEL	T3	PA QL(2 TABS/30 DAYS)
MALARONE (*atovaquone-proguanil hcl*)	T3	PA
mefloquine hcl	T1	
PRIMAQUINE (*primaquine phosphate*)	T1	
primaquine phosphate (Primaquine)	T1	
pyrimethamine 25 mg tablet (Daraprim)	T1	PA SP
quinine sulfate	T1	
ANTI-PROTOZOAL DRUGS, MISCELLANEOUS		
atovaquone (Mepron)	T1	
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
NEBUPENT (*pentamidine isethionate*)	T3	
pentamidine isethionate (Nebupent)	T1	
ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)		
ANTIBACTERIAL AGENTS, MISCELLANEOUS		
glycine urologic solution	T1	

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ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTISEPTICS,GENERAL		
ALCOHOL SWABSTICK	T3	
CVS ISOPROPYL ALCOHOL 91% SPRY	T1	
GS ISOPROPYL ALCOHOL 70% SPRAY	T1	
ISOPROPYL ALCOHOL 70% SPRAY	T1	
MEDI-FIRST ISOPROPYL ALCOHOL	T3	
ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADBM(CF) 10 MG SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
ADALIMUMAB-ADBM(CF) 20 MG SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
ADALIMUMAB-ADBM(CF) 40 MG SYRG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
ADALIMUMAB-ADBM(CF) PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
ADALIMUMAB-RYVK(CF)	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
ADALIMUMAB-RYVK(CF) AUTOINJECT	T2	PA QL SP HD
AVSOLA	T2	PA SP HD
CIMZIA (2 PACK)	T2	PA QL(1 KIT/28 DAYS) SP HD
CIMZIA 200 MG/ML SYRINGE KIT	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP
CIMZIA 2X200 MG/ML(X3)START KT	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
CYLTEZO(CF) 10 MG/0.2 ML SYRNG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
CYLTEZO(CF) 20 MG/0.4 ML SYRNG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
CYLTEZO(CF) 40 MG/0.4 ML SYRNG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
CYLTEZO(CF) 40 MG/0.8 ML SYRNG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
CYLTEZO(CF) PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
CYLTEZO(CF) PEN CROHN'S-UC-HS	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
CYLTEZO(CF) PEN PSORIASIS-UV	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T2	PA QL(8 MLS/28 DAYS) SP HD
ENBREL 25 MG/0.5 ML VIAL	T2	PA QL(8 MLS/28 DAYS) SP HD
ENBREL 50 MG/ML SYRINGE	T2	PA QL(4 MLS/28 DAYS) SP HD
ENBREL MINI	T2	PA QL(4 MLS/28 DAYS) SP HD
ENBREL SURECLICK	T2	PA QL(4 MLS/28 DAYS) SP HD

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ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR *(cont.)*		
HUMIRA	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
HUMIRA PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
HUMIRA(CF) 10 MG/0.1 ML SYRING	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
HUMIRA(CF) 20 MG/0.2 ML SYRING	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
HUMIRA(CF) 40 MG/0.4 ML SYRING	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
HUMIRA(CF) PEN 40 MG/0.4 ML	T2	PA QL(4 KITS/28 DAYS) SP HD
HUMIRA(CF) PEN 80 MG/0.8 ML	T3	PA QL(2 PENS/28 DAYS) SP HD
HUMIRA(CF) PEN CROHN'S-UC-HS	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
INFLECTRA	T2	PA SP HD
INFLIXIMAB	T2	PA SP HD
REMICADE	T2	PA SP HD
SIMLANDI(CF) 20 MG/0.2 ML SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMLANDI(CF) 40 MG/0.4 ML SYRG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
SIMLANDI(CF) 80 MG/0.8 ML SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMLANDI(CF) AI 40 MG/0.4 ML	T2	PA QL SP HD
SIMLANDI(CF) AI 80 MG/0.8 ML	T2	PA QL(2 AUTO-INJS/28 DAYS) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T2	PA QL(1 PEN/28 DAYS) SP HD
SIMPONI 100 MG/ML SYRINGE	T2	PA QL(1 SYRINGE/28 DAYS) SP HD
SIMPONI ARIA	T2	PA SP HD
ANTI-NEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
*bexarotene 75 mg capsule (*Targretin*)*	T1	PA SP HD CSL
ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
ZOLINZA	T2	PA SP HD
ANTI-NEOPLASTIC - ALKYLATING AGENTS		
ALKERAN (melphalan)	T3	SP CSL
cyclophosphamide 25 mg capsule	T1	SP HD CSL
cyclophosphamide 50 mg capsule	T1	SP HD CSL
GLEOSTINE	T2	CSL
HYDREA (hydroxyurea)	T3	CSL
*hydroxyurea (*Hydrea*)*	T1	CSL

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC - ALKYLATING AGENTS *(cont.)*		
LEUKERAN	T2	CSL
lomustine	T1	CSL
MYLERAN	T2	CSL
temozolomide	T1	PA SP HD CSL
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS		
abiraterone acetate (Zytiga)	T1	PA CSL
abiraterone acetate 250 mg tab (Zytiga)	T1	PA SP HD CSL
abiraterone acetate 500 mg tab (Zytiga)	T1	PA SP HD CSL
bicalutamide (Casodex)	T1	CSL
CASODEX (*bicalutamide*)	T3	CSL
ERLEADA	T2	PA SP HD CSL
EULEXIN (*flutamide*)	T3	CSL
flutamide (Eulexin)	T1	CSL
nilutamide (Nilandron)	T1	QL(4 TABS/DAY) CSL
NUBEQA	T2	PA SP HD CSL
XTANDI	T2	PA SP HD CSL
ANTI-NEOPLASTIC - ANTI-METABOLITES		
capecitabine 150 mg tablet (Xeloda)	T1	PA SP HD CSL
capecitabine 500 mg tablet (Xeloda)	T1	PA SP HD CSL
INQOVI	T3	PA SP HD CSL
JYLAMVO	T3	CSL
LONSURF	T3	PA SP HD CSL
mercaptopurine 20 mg/ml suspen (Purixan)	T1	SP CSL
mercaptopurine 50 mg tablet	T1	CSL
methotrexate 2.5 mg tablet	T1	CSL
methotrexate 250 mg/10 ml vial	T1	
methotrexate 50 mg/2 ml vial	T1	
methotrexate sodium/pf	T1	

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC - ANTI-METABOLITES *(cont.)*		
ONUREG	T3	PA QL(14 TABS/28 DAYS) SP CSL
PURIXAN (*mercaptopurine*)	T3	SP CSL
TABLOID	T3	CSL
TREXALL	T2	CSL
XATMEP	T3	CSL
XELODA (*capecitabine*)	T3	PA SP HD CSL
ANTI-NEOPLASTIC - AROMATASE INHIBITORS		
anastrozole (Arimidex)	T1	HD PPACA CSL
ARIMIDEX (*anastrozole*)	T3	HD CSL
AROMASIN (*exemestane*)	T3	HD CSL
exemestane (Aromasin)	T1	HD PPACA CSL
letrozole (Femara)	T1	HD CSL
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS		
OJEMDA 25 MG/ML ORAL SUSP	T3	PA QL(8 BOTTLES/28 DAYS) SP CSL
OJEMDA 100 MG TAB (400MG DOSE)	T3	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (500MG DOSE)	T3	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (600MG DOSE)	T3	PA QL(1 PACKET/28 Days) SP CSL
TAFINLAR 10 MG TABLET FOR SUSP	T2	PA QL(30 TABS/DAY) SP HD CSL
TAFINLAR 50 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP HD CSL
TAFINLAR 75 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP HD CSL
ZELBORAF	T2	PA SP HD CSL
ANTINEOPLASTIC - EGFR AND MET RECEPTOR INHIB, MAB		
RYBREVANT	T3	PA SP
ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO	T3	PA SP HD CSL
ERIVEDGE	T2	PA SP HD CSL
ODOMZO	T2	PA SP HD CSL
ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T3	PA QL(2 TABS/DAY) SP HD CSL

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS 120 MG TABLET	T3	PA QL(8 TABS/DAY) SP HD CSL
LUMAKRAS 240 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD CSL
LUMAKRAS 320 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
ANTI-NEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS		
COTELLIC	T2	PA SP HD CSL
GOMEKLI	T3	PA SP CSL
KOSELUGO 10 MG CAPSULE	T3	PA QL(10 CAPS/DAY) SP CSL
KOSELUGO 25 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP CSL
KOSELUGO 5 MG SPRINKLE CAPSULE	T3	PA QL(20 CAPS/DAY) SP CSL
KOSELUGO 7.5 MG SPRINKLE CAP	T3	PA QL(12 CAPS/DAY) SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T2	PA QL(40 MLS/DAY) SP HD CSL
MEKINIST 0.5 MG TABLET	T2	PA QL(3 TABS/DAY) SP HD CSL
MEKINIST 2 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD CSL
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS		
everolimus (Afinitor)	T1	PA QL(1 TAB/DAY) SP CSL
everolimus 10 mg tablet (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
everolimus 2 mg tab for susp (Afinitor Disperz)	T1	PA QL(1 TAB/DAY) SP CSL
everolimus 2.5 mg tablet (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
everolimus 3 mg tab for susp (Afinitor Disperz)	T1	PA QL(1 TAB/DAY) SP CSL
everolimus 5 mg tab for susp (Afinitor Disperz)	T1	PA QL(1 TAB/DAY) SP CSL
everolimus 5 mg tablet (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
everolimus 7.5 mg tablet (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
FYARRO	T3	PA SP
ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T3	PA SP CSL
ANTINEOPLASTIC - SYSTEMIC ENZYME INHIBITORS COMBS		
AVMAPKI-FAKZYNJA	T3	PA SP CSL
ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T3	PA SP HD CSL
ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA CO-PACK	T2	PA QL(1 TAB/28 DAYS) SP CSL
ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
PHESGO	T3	PA SP HD

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS		
lenalidomide	T1	PA QL(1 CAP/DAY) SP HD CSL
POMALYST	T2	PA QL(21 CAPS/28 DAYS) SP HD CSL
REVLIMID	T2	PA QL(1 CAP/DAY) SP HD CSL
ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPR.		
leuprolide acetate	T1	PA SP HD
LEUPROLIDE DEPOT	T3	PA SP
LUPRON DEPOT 22.5 MG 3MO KIT	T3	PA SP HD
LUPRON DEPOT 45 MG 6MO KIT	T3	PA SP HD
LUPRON DEPOT 7.5 MG KIT	T3	PA SP HD
LUPRON DEPOT-4 MONTH KIT	T3	PA SP HD
LUTRATE DEPOT	T3	PA SP
ZOLADEX	T2	PA SP HD
ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS		
FIRMAGON	T3	PA SP HD
ORGOVYX	T3	PA SP CSL
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T2	PA QL(8 CAPS/DAY) SP HD CSL
ALUNBRIG 180 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 30 MG TABLET	T2	PA QL(2 TABS/DAY) SP CSL
ALUNBRIG 90 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T2	PA QL(1 TAB/DAY) SP CSL
AYVAKIT	T3	PA QL(1 TAB/DAY) SP CSL
BALVERSA	T3	PA SP CSL
BOSULIF 100 MG CAPSULE	T3	PA QL(3 CAPS/DAY) SP HD CSL
BOSULIF 100 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
BOSULIF 50 MG CAPSULE	T3	PA QL(3 CAPS/DAY) SP HD CSL
BOSULIF 500 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD CSL
BRUKINSA 160 MG TABLET	T2	PA QL(2 TABS/DAY) SP CSL
BRUKINSA 80 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP CSL
CABOMETYX	T2	PA SP HD CSL
CALQUENCE	T2	PA SP CSL
CAPRELSA 100 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
CAPRELSA 300 MG TABLET	T3	PA QL(1 TAB/DAY) SP CSL
COMETRIQ 100 MG DAILY-DOSE PK	T3	PA QL(56 CAPS/28 DAYS) SP HD CSL

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(con't.)*		
COMETRIQ 140 MG DAILY-DOSE PK	T3	PA QL(112 CAPS/28 DAYS) SP HD CSL
COMETRIQ 60 MG DAILY-DOSE PACK	T3	PA QL(84 CAPS/28 DAYS) SP HD CSL
COPIKTRA	T3	PA SP CSL
DANZITEN	T2	PA SP CSL
*dasatinib 100 mg tablet (*Sprycel*)*	T1	QL(1 TAB/DAY) SP HD CSL
*dasatinib 140 mg tablet (*Sprycel*)*	T1	QL(1 TAB/DAY) SP HD CSL
*dasatinib 20 mg tablet (*Sprycel*)*	T1	QL(3 TABS/DAY) SP HD CSL
*dasatinib 50 mg tablet (*Sprycel*)*	T1	QL(1 TAB/DAY) SP HD CSL
*dasatinib 70 mg tablet (*Sprycel*)*	T1	QL(2 TABS/DAY) SP HD CSL
*dasatinib 80 mg tablet (*Sprycel*)*	T1	QL(1 TAB/DAY) SP HD CSL
ENSACOVE 25 MG CAPSULE	T2	PA QL(9 CAPS/DAY) SP CSL
ENSACOVE 100 MG CAPSULE	T2	PA QL(2 CAPS/DAY) SP CSL
erlotinib hcl	T1	PA SP HD CSL
FOTIVDA	T3	PA QL(21 CAPS/28 DAYS) SP CSL
FRUZAQLA 1 MG CAPSULE	T2	PA QL(84 CAPS/28 DAYS) SP CSL
FRUZAQLA 5 MG CAPSULE	T2	PA QL(21 CAPS/28 DAYS) SP CSL
GAVRETO	T3	PA QL(4 CAPS/DAY) SP CSL
*gefitinib (*Iressa*)*	T1	PA SP HD CSL
GILOTRIF	T3	PA SP HD CSL
IBRANCE 100 MG CAPSULE	T3	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 100 MG TABLET	T3	PA QL(21 TABS/28 DAYS) SP HD CSL
IBRANCE 125 MG CAPSULE	T3	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 125 MG TABLET	T3	PA QL(21 TABS/28 DAYS) SP HD CSL
IBRANCE 75 MG CAPSULE	T3	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 75 MG TABLET	T3	PA QL(21 TABS/28 DAYS) SP HD CSL
IBTROZI	T3	PA SP CSL
imatinib mesylate 100 mg tab (Gleevec)	T1	QL(6 TABS/DAY) SP HD CSL

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
imatinib mesylate 400 mg tab (Gleevec)	T1	QL(2 TABS/DAY) SP HD CSL
IMBRUVICA 140 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP CSL
IMBRUVICA 140 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 280 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 420 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 70 MG CAPSULE	T2	PA QL(1 CAP/DAY) SP CSL
IMBRUVICA 70 MG/ML SUSPENSION	T2	PA QL(8 MLS/DAY) SP CSL
IMKELDI	T2	PA SP CSL
INLYTA	T3	PA SP HD CSL
INREBIC	T3	PA SP HD CSL
IRESSA (*gefitinib*)	T3	PA SP HD CSL
ITOVEBI	T3	PA SP HD CSL
IWILFIN	T3	PA QL(8 TABS/DAY) SP CSL
JAYPIRCA 100 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
JAYPIRCA 50 MG TABLET	T3	PA QL(1 TAB/DAY) SP CSL
KISQALI 200 MG DAILY DOSE	T2	PA QL(21 TABS/28 DAYS) SP HD CSL
KISQALI 400 MG DAILY DOSE	T2	PA QL(42 TABS/28 DAYS) SP HD CSL
KISQALI 600 MG DAILY DOSE	T2	PA QL(63 TABS/28 DAYS) SP HD CSL
lapatinib ditosylate (Tykerb)	T1	PA QL(6 TABS/DAY) SP HD CSL
LAZCLUZE	T3	PA SP CSL
LENVIMA	T2	PA SP HD CSL
LORBRENA 25 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
LORBRENA 100 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD CSL
LYNPARZA	T2	PA QL(4 TABS/DAY) SP HD CSL
LYTGOBI 12 MG DOSE (3X 4MG TB)	T3	PA QL(3 TABS/DAY) SP CSL
LYTGOBI 16 MG DOSE (4X 4MG TB)	T3	PA QL(4 TABS/DAY) SP CSL
LYTGOBI 20 MG DOSE (5X 4MG TB)	T3	PA QL(5 TABS/DAY) SP CSL
NERLYNX	T3	PA SP HD CSL
nilotinib hcl (Tasigna)	T1	PA QL(4 CAPS/DAY) SP HD CSL
NINLARO	T3	PA QL(3 CAPS/28 DAYS) SP HD CSL
OGSIVEO 100 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
OGSIVEO 150 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
OGSIVEO 50 MG TABLET	T3	PA QL(6 TABS/DAY) SP CSL

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
OJJAARA	T3	PA QL(1 TAB/DAY) SP CSL
pazopanib hcl 200 mg tablet (Votrient)	T1	PA QL(4 TABS/DAY) SP CSL
PEMAZYRE	T3	PA QL(14 TABS/21 DAYS) SP CSL
PIQRAY	T2	PA SP CSL
QINLOCK	T3	PA QL(3 TABS/DAY) SP CSL
RETEVMO 40 MG CAPSULE	T3	PA QL(6 CAPS/DAY) SP HD CSL
RETEVMO 40 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
RETEVMO 80 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP HD CSL
RETEVMO 80 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD CSL
RETEVMO 120 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD CSL
RETEVMO 160 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD CSL
REVUFORJ 25 MG TABLET	T3	PA QL(4 TABS/DAY) SP CSL
REVUFORJ 110 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
REVUFORJ 160 MG TABLET	T3	PA QL(8 TABS/DAY) SP CSL
ROMVIMZA	T3	PA QL(8 CAPS/28 DAYS) SP CSL
ROZLYTREK	T3	PA SP HD CSL
RUBRACA	T2	PA QL(4 TABS/DAY) SP CSL
RYDAPT	T3	PA SP HD CSL
SCEMBLIX 20 MG TABLET	T2	PA QL(2 TABS/DAY) SP CSL
SCEMBLIX 40 MG TABLET	T2	PA SP CSL
SCEMBLIX 100 MG TABLET	T2	PA SP CSL
sorafenib tosylate (Nexavar)	T1	PA QL(4 TABS/DAY) SP HD CSL
STIVARGA	T2	PA QL(84 TABS/28 DAYS) SP HD CSL
sunitinib malate (Sutent)	T1	PA QL(1 CAP/DAY) SP HD CSL
TABRECTA	T3	PA QL(4 TABS/DAY) SP HD CSL
TAGRISSO	T3	PA SP HD CSL
TALZENNA 0.1 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.1 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.35 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.5 MG CAPSULE	T3	PA SP CSL

T1 – Typically Generics
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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
TALZENNA 0.5 MG SOFTGEL	T3	PA SP CSL
TALZENNA 0.75 MG SOFTGEL	T3	PA SP CSL
TALZENNA 1 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 1 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TEPMETKO	T3	PA QL(2 TABS/DAY) SP CSL
TRUQAP	T2	PA QL(64 TABS/28 DAYS) SP CSL
TUKYSA	T3	PA SP CSL
TURALIO	T3	PA QL(4 CAPS/DAY) SP CSL
VANFLYTA	T3	PA QL(2 TABS/DAY) SP CSL
VERZENIO	T2	PA QL(2 TABS/DAY) SP HD CSL
VITRAKVI	T3	PA SP HD CSL
VIZIMPRO	T3	PA SP HD CSL
VONJO	T3	PA QL(4 CAPS/DAY) SP CSL
XALKORI 150 MG PELLET	T3	PA QL(6 PELLETS/DAY) SP HD CSL
XALKORI 20 MG PELLET	T3	PA QL(4 PELLETS/DAY) SP HD CSL
XALKORI 200 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP HD CSL
XALKORI 250 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP HD CSL
XALKORI 50 MG PELLET	T3	PA QL(4 PELLETS/DAY) SP HD CSL
XOSPATA	T3	PA SP CSL
ZEJULA	T2	PA QL(1 TAB/DAY) SP CSL
ZYDELIG	T3	PA QL(2 TABS/DAY) SP HD CSL
ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-I (PD-I) MAB		
LIBTAYO	T2	PA SP
OPDIVO	T3	PA SP HD
ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T2	PA SP CSL
VENCLEXTA STARTING PACK	T2	PA SP CSL
ANTINEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T3	PA QL(2 TABS/DAY) SP CSL
ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH		
WELIREG	T3	PA QL(3 TABS/DAY) SP CSL
ANTINEOPLASTIC-IMMUNOTHERAPY CHECKPOINT INHIB COMB		
OPDUALAG	T3	PA SP HD

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T3	PA SP HD CSL
REZLIDHIA	T3	PA QL(2 CAPS/DAY) SP CSL
TIBSOVO	T3	PA SP CSL
VORANIGO	T3	PA SP CSL
ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES		
ENHERTU	T3	PA SP HD
TIVDAK	T3	PA SP HD
ZYNLONTA	T3	PA SP
ANTI-NEOPLASTICS, MISCELLANEOUS		
etoposide	T1	SP HD CSL
LYSODREN	T2	CSL
MATULANE	T2	SP CSL
tretinoin 10 mg capsule	T1	PA CSL
ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T3	PA SP CSL
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
YERVOY	T3	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T2	PA SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (*toremifene citrate*)	T3	QL(2 TABS/DAY) HD CSL
ORSERDU 345 MG TABLET	T3	PA QL(1 TAB/DAY) SP CSL
ORSERDU 86 MG TABLET	T3	PA QL(3 TABS/DAY) SP CSL
SOLTAMOX	T2	HD CSL
tamoxifen citrate	T1	HD PPACA CSL
toremifene citrate (Fareston)	T1	QL(2 TABS/DAY) HD CSL
STEROID ANTI-NEOPLASTICS		
megestrol 20 mg tablet	T1	CSL
megestrol 40 mg tablet	T1	CSL
ANTI-NEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T3	SP

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List of Prescription Medications

ANTI-NEOPLASTICS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS		
EFUDEX (*fluorouracil*)	T3	
FLUOROPLEX	T2	
fluorouracil	T1	
FLUOROURACIL	T1	
fluorouracil (Efudex)	T1	
PANRETIN	T3	SP HD
VALCHLOR	T3	SP HD
ANTI-OBESITY DRUGS (Weight Management)		
ANTI-OBESITY - ANOREXIC AGENTS		
benzphetamine hcl	T1	
diethylpropion hcl	T1	
LOMAIRA	T3	PA
phendimetrazine tartrate	T1	
phentermine 15 mg capsule	T1	
phentermine 30 mg capsule	T1	
phentermine 37.5 mg capsule	T1	
phentermine 37.5 mg tablet	T1	
phentermine 8 mg tablet	T1	PA
phentermine/topiramate (Qsymia)	T1	
QSYMIA *(phentermine/topiramate)*	T3	PA
ANTI-OBESITY - INCRETIN MIMETICS COMBINATION		
ZEPBOUND 2.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/365 DAYS)
ZEPBOUND 5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
ZEPBOUND 7.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
ZEPBOUND 10 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
ZEPBOUND 12.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
ZEPBOUND 15 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS		
IMCIVREE	T3	PA QL(9 MLS/30 DAYS) SP
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEP AGONIST		
liraglutide 18 mg/3 ml pen (Saxenda)	T1	PA
liraglutide 5-pak 18 mg/3 ml (Saxenda)	T1	PA
SAXENDA *(liraglutide)*	T3	PA
WEGOVY	T2	PA QL(4 PENS/28 DAYS)

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List of Prescription Medications

ANTI-OBESITY DRUGS (Weight Management) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS		
BELVIQ	T3	PA
BELVIQ XR	T3	PA
ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB		
CONTRAVE	T3	PA
FAT ABSORPTION DECREASING AGENTS		
XENICAL	T3	PA
ANTI-PARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T2	PA QL(10 MLS/56 DAYS) SP
ANTI-PARASITICS (Infections)		
ANTI-PARASITICS		
ALINIA 100 MG/5 ML SUSPENSION	T3	
nitazoxanide (Alinia)	T1	
TOPICAL ANTI-PARASITICS		
crotamiton	T1	
ELIMITE *(permethrin)*	T3	
EURAX	T3	
lindane	T1	
malathion (Ovide)	T1	
OVIDE *(malathion)*	T3	
permethrin (Elimite)	T1	
spinosad (Natroba)	T1	
ULESFIA	T3	
lindane	T1	
malathion (Ovide)	T1	
OVIDE *(malathion)*	T3	
ANTI-PARKINSON DRUGS (Parkinson's Disease)		
ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC		
benztropine mesylate	T1	HD
trihexyphenidyl hcl	T1	HD

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List of Prescription Medications

ANTI-PARKINSON DRUGS (Parkinson's Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PARKINSONISM DRUGS, OTHER		
amantadine hcl	T1	HD
APOKYN	T2	PA SP HD
apomorphine hcl	T1	HD
bromocriptine mesylate	T1	HD
carbidopa/levodopa	T1	HD
carbidopa/levodopa (Sinemet)	T1	HD
carbidopa/levodopa/entacapone	T1	HD
carbidopa/levodopa/entacapone (Stalevo 100)	T1	HD
carbidopa/levodopa/entacapone (Stalevo 75)	T1	HD
carbidopa-levo er 25-100 tab	T1	HD
carbidopa-levo er 50-200 tab	T1	HD
CREXONT	T3	ST HD
DUOPA	T3	SP HD
entacapone	T1	HD
INBRIJA	T3	PA SP HD
NEUPRO	T3	HD
NOURIANZ	T3	PA QL(1 TAB/DAY) SP HD
pramipexole di-hcl	T1	HD
pramipexole er 0.375 mg tablet	T1	QL(1 TAB/DAY) HD
pramipexole er 0.75 mg tablet	T1	HD
pramipexole er 1.5 mg tablet (Mirapex Er)	T1	QL(1 TAB/DAY) HD
pramipexole er 2.25 mg tablet	T1	QL(1 TAB/DAY) HD
pramipexole er 3 mg tablet	T1	HD
pramipexole er 3.75 mg tablet	T1	HD
pramipexole er 4.5 mg tablet	T1	HD
rasagiline mesylate 0.5 mg tab (Azilect)	T1	QL(1 TAB/DAY) HD
rasagiline mesylate 1 mg tab (Azilect)	T1	HD
ANTI-PARKINSONISM DRUGS, OTHER		
ropinirole hcl	T1	HD
RYTARY	T3	ST HD

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List of Prescription Medications

ANTI-PARKINSON DRUGS (Parkinson's Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PARKINSONISM DRUGS, OTHER *(cont.)*		
selegiline hcl	T1	HD
SINEMET (*carbidopa/levodopa*)	T3	HD
STALEVO 75 (*carbidopa-levodopa-entacapone*)	T3	HD
STALEVO 100 (*carbidopa-levodopa-entacapone*)	T3	HD
TASMAR (*tolcapone*)	T3	HD
tolcapone (Tasmar)	T1	HD
XADAGO	T3	ST HD
DECARBOXYLASE INHIBITORS		
carbidopa (Lodosyn)	T1	
ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
aspirin/dipyridamole	T1	HD
ASPIRIN-OMEPRAZOLE DR 81-40 MG	T1	HD
cilostazol	T1	HD
clopidogrel bisulfate	T1	HD
clopidogrel bisulfate (Plavix)	T1	HD
dipyridamole	T1	HD
prasugrel hcl (Effient)	T1	HD
ticagrelor (Brilinta)	T1	HD
ZONTIVITY	T1	HD
PLATELET AGGREGATION INHIBITORS		
EFFIENT (*prasugrel hcl*)	T3	HD
prasugrel hcl (Effient)	T1	HD
ticagrelor	T1	HD
ticlopidine hcl	T1	HD
PLATELET REDUCING AGENTS		
AGRYLIN (*anagrelide hcl*)	T3	
anagrelide hcl	T1	
anagrelide hcl (Agrylin)	T1	

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-RETROVIRAL - CAPSID INHIBITORS		
SUNLENCA 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
SUNLENCA 4- 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
SUNLENCA 463.5 MG/1.5 ML VIAL	T3	PA SP
SUNLENCA 5- 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
ANTIRETROVIRAL - CAPSID INHIBITORS (PREP)		
YEZTUGO 463.5 MG/1.5 ML VIAL	T2	SP PPACA
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.		
CABENUVA	T3	PA SP
JULUCA	T2	QL(1 TAB/DAY) SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB.		
DOVATO	T2	QL(1 TAB/DAY) SP
ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ	T2	QL(1 TAB/DAY) SP
TRIUMEQ PD	T2	QL(6 TABS/DAY) SP
ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T2	QL(1 TAB/DAY) SP
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T2	PA SP
darunavir (Prezista)	T1	SP
PREZCOBIX	T3	PA SP
PREZISTA 100 MG/ML SUSPENSION	T2	SP
PREZISTA 150 MG TABLET	T2	SP
PREZISTA 75 MG TABLET	T2	SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T3	PA SP
DESCOVY 120-15 MG TABLET	T2	SP
DESCOVY 200-25 MG TABLET	T2	SP PPACA
emtricitabine-tenofv 100-150mg (Truvada)	T1	SP
emtricitabine-tenofv 133-200mg (Truvada)	T1	SP
emtricitabine-tenofv 167-250mg (Truvada)	T1	SP
emtricitabine-tenofv 200-300mg (Truvada)	T1	SP PPACA
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB		
abacavir sulfate/lamivudine (Epzicom)	T1	PA SP
lamivudine/zidovudine (Combivir)	T1	SP

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
maraviroc (Selzentry)	T1	PA SP
SELZENTRY 20 MG/ML ORAL SOLN	T2	PA SP
ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR		
RUKOBIA	T3	PA QL(2 TABS/DAY) SP
ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T2	PA SP
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
FUZEON	T2	PA SP
EDURANT	T3	PA SP
EDURANT PED	T3	PA SP
efavirenz	T1	PA SP
etravirine (Intelence)	T1	SP
INTELENCE 25 MG TABLET	T3	PA SP
nevirapine	T1	PA SP
PIFELTRO	T3	PA SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
abacavir sulfate	T1	PA SP
abacavir sulfate (Ziagen)	T1	PA SP
emtricitabine (Emtriva)	T1	SP
EMTRIVA 10 MG/ML SOLUTION	T2	PA SP
lamivudine 10 mg/ml oral soln (Epivir)	T1	SP
lamivudine 150 mg tablet (Epivir)	T1	SP
lamivudine 300 mg tablet (Epivir)	T1	PA SP
lamivudine 300 mg/30ml sol cup (Epivir)	T1	SP
zidovudine	T1	SP
zidovudine (Retrovir)	T1	SP
tenofovir disoproxil fumarate (Viread)	T1	PA SP
VIREAD 150 MG TABLET	T2	PA SP
VIREAD 200 MG TABLET	T2	PA SP
VIREAD 250 MG TABLET	T2	PA SP
VIREAD POWDER	T2	PA SP

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ANTIVIRALS (AIDS/HIV) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
lopinavir/ritonavir	T1	SP
*lopinavir/ritonavir (*Kaletra*)*	T1	SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS		
atazanavir sulfate	T1	PA SP
atazanavir sulfate (Reyataz)	T1	PA SP
EVOTAZ	T3	PA SP
fosamprenavir calcium	T1	PA SP
NORVIR 100 MG POWDER PACKET	T2	SP
REYATAZ 50 MG POWDER PACKET	T2	PA SP
*ritonavir (*Norvir*)*	T1	SP
ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T2	SP PPACA
ISENTRESS	T2	SP
ISENTRESS HD	T2	PA SP
TIVICAY	T2	SP
TIVICAY PD	T2	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
DELSTRIGO	T3	PA QL(1 TAB/DAY) SP
efavirenz/emtricit/tenofovr df	T1	QL(1 TAB/DAY) SP
efavirenz/lamivu/tenofov disop (Symfi Lo)	T1	QL(1 TAB/DAY) SP
efavirenz/lamivu/tenofov disop (Symfi)	T1	QL(1 TAB/DAY) SP
emtricita/rilpivirine/tenof df (Complera)	T1	QL(1 TAB/DAY) SP
ODEFSEY	T3	PA QL(1 TAB/DAY) SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T2	QL(1 TAB/DAY) SP
GENVOYA	T2	QL(1 TAB/DAY) SP
STRIBILD	T3	PA QL(1 TAB/DAY) SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
trifluridine	T1	
ZIRGAN	T3	

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ANTIVIRALS (Infections)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRAL - MAIN PROTEASE (MPRO) INHIBITOR		
PAXLOVID	T2	QL(1 TAB/120 DAYS)
ANTIVIRAL - RNA POLYMERASE INHIBITOR		
LAGEVRIO (EUA)	T2	QL(1 PACK/120 DAYS)
ANTIVIRAL MONOCLONAL ANTIBODIES		
BEYFORTUS	T3	PPACA
ANTIVIRALS, GENERAL		
acyclovir 200 mg capsule	T1	
acyclovir 200 mg/5 ml susp	T1	
acyclovir 200 mg/5 ml susp cup	T1	
acyclovir 400 mg tablet	T1	
acyclovir 800 mg tablet	T1	
acyclovir 800 mg/20ml susp cup	T1	
famciclovir	T1	
FLUMADINE (*rimantadine hcl*)	T3	
LIVTENCITY	T3	PA QL(4 TABS/DAY) SP
oseltamivir 6 mg/ml suspension (Tamiflu)	T1	QL(180 MLS/30 DAYS)
oseltamivir phos 30 mg capsule (Tamiflu)	T1	QL(20 CAPS/30 DAYS)
oseltamivir phos 45 mg capsule (Tamiflu)	T1	QL(10 CAPS/30 DAYS)
oseltamivir phos 75 mg capsule (Tamiflu)	T1	QL(10 CAPS/30 DAYS)
PREVYMIS 120 MG PELLET PACKET	T3	SP
PREVYMIS 20 MG PELLET PACKET	T3	SP
PREVYMIS 240 MG TABLET	T3	SP HD
PREVYMIS 480 MG TABLET	T3	SP HD
RELENZA	T3	QL(20 BLISTERS/30 DAYS)
rimantadine hcl (Flumadine)	T1	
TAMIFLU 30 MG CAPSULE (*oseltamivir phosphate*)	T3	QL(20 CAPS/30 DAYS)
TAMIFLU 45 MG CAPSULE (*oseltamivir phosphate*)	T3	QL(10 CAPS/30 DAYS)
TAMIFLU 6 MG/ML SUSPENSION (*oseltamivir phosphate*)	T3	QL(180 MLS/30 DAYS)
TAMIFLU 75 MG CAPSULE (*oseltamivir phosphate*)	T3	QL(10 CAPS/30 DAYS)
TEMBEXA	T3	
valacyclovir hcl (Valtrex)	T1	

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ANTIVIRALS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, GENERAL *(cont.)*		
valganciclovir hcl (Valcyte)	T1	
VALTREX (*valacyclovir hcl*)	T3	
XOFLUZA	T3	QL(2 TABS/30 DAYS)
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T2	PA QL(1 TAB/DAY) SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 150-37.5 MG PELLET PKT	T2	PA QL(1 PACK/DAY) SP HD
EPCLUSA 200 MG-50 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
EPCLUSA 200-50 MG PELLET PACK	T2	PA QL(1 PACK/DAY) SP HD
EPCLUSA 400 MG-100 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
HARVONI 33.75-150 MG PELLET PK	T2	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG PELLET PACKT	T2	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
HARVONI 90-400 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
HEPATITIS B TREATMENT AGENTS		
adefovir dipivoxil	T1	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T2	SP HD
entecavir 0.5 mg tablet (Baraclude)	T1	QL(1 TAB/DAY) SP HD
entecavir 1 mg tablet (Baraclude)	T1	SP HD
lamivudine	T1	SP
VEMLIDY	T2	SP HD
HEPATITIS C TREATMENT AGENTS		
PEGASYS	T2	PA SP HD
ribavirin	T1	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T2	PA QL(1 TAB/DAY) SP HD
ANTIVIRALS (Skin Conditions)		
TOPICAL GENITAL WART-HPV TREATMENT AGENTS		
VEREGEN	T3	
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
epinephrine 0.15 mg auto-injct (Epipen Jr 2-Pak)	T1	QL(4 UNITS/30 DAYS)
epinephrine 0.15 mg auto-injct (Epipen Jr)	T1	QL(4 UNITS/30 DAYS)

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List of Prescription Medications

AUTONOMIC DRUGS (Allergy/Nasal Sprays) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANAPHYLAXIS THERAPY AGENTS *(cont.)*		
epinephrine 0.3 mg auto-inject (Epipen 2-Pak)	T1	QL(4 UNITS/30 DAYS)
epinephrine 0.3 mg auto-inject (Epipen)	T1	QL(4 UNITS/30 DAYS)
AUTONOMIC DRUGS (Alzheimer's Disease)		
CHOLINESTERASE INHIBITORS		
ARICEPT	T2	PA QL(4 PATCHES/28 DAYS) HD
donepezil hcl	T1	HD
donepezil hcl (Aricept)	T1	HD
EXELON (*rivastigmine*)	T3	HD
galantamine er 16 mg capsule	T1	HD
galantamine er 24 mg capsule	T1	HD
galantamine er 8 mg capsule	T1	QL(1 CAP/DAY) HD
galantamine hbr	T1	HD
pyridostigmine 60 mg/5 ml cup (Mestinon)	T1	HD
pyridostigmine 60 mg/5 ml soln (Mestinon)	T1	HD
pyridostigmine br 60 mg tablet (Mestinon)	T1	HD
pyridostigmine bromide (Mestinon)	T1	HD
rivastigmine (Exelon)	T1	HD
rivastigmine tartrate	T1	HD
AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)[10]		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
amphetamine sulfate (Evekeo)	T1	PA
dextroamphetamine er 10 mg cap (Dexedrine)	T1	PA QL(1 CAP/DAY)
dextroamphetamine er 15 mg cap (Dexedrine)	T1	PA QL(3 CAPS/DAY)
dextroamphetamine er 5 mg cap	T1	PA QL(1 CAP/DAY)
dextroamphetamine sulfate	T1	PA
dextroamphetamine sulfate (Zenzedi)	T1	PA
dextroamphetamine/amphetamine (Adderall Xr)	T1	PA QL(1 CAP/DAY)
dextroamphetamine/amphetamine (Adderall)	T1	PA
dextroamphetamine/amphetamine (Mydayis)	T1	PA QL(1 CAP/DAY)
methamphetamine hcl (Desoxyn)	T1	PA
XELSTRYM	T3	PA QL(1 PATCH/DAY)
ZENZEDI	T3	PA ST
ZENZEDI *(dextroamphetamine sulfate)*	T3	PA ST

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
ADRENERGIC VASOPRESSOR AGENTS		
droxidopa 100 mg capsule (Northera)	T1	SP HD
droxidopa 200 mg capsule (Northera)	T1	SP HD
droxidopa 300 mg capsule (Northera)	T1	SP HD
midodrine hcl	T1	
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLINE (*phenoxybenzamine hcl*)	T3	HD
phenoxybenzamine hcl (Dibenzyline)	T1	HD
AUTONOMIC DRUGS (Urinary Tract Conditions)		
PARASYMPATHETIC AGENTS		
bethanechol chloride	T1	HD
cevimeline hcl (Evoxac)	T1	HD
pilocarpine hcl 5 mg tablet (Salagen)	T1	HD
pilocarpine hcl 7.5 mg tablet (Salagen)	T1	HD
SALAGEN (*pilocarpine hcl*)	T3	HD
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T3	PA QL(1 TAB/DAY)
ODACTRA	T3	PA QL(1 TAB/DAY)
ORALAIR	T3	PA QL(1 TAB/DAY)
RAGWITEK	T3	PA QL(1 TAB/DAY)
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T3	PA SP HD
BIOLOGICALS (Miscellaneous)		
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ	T3	PA SP HD
BIOLOGICALS (Vaccines)		
COVID-19 VACCINES		
COMIRNATY	T2	PPACA
COMIRNATY 2023-2024	T2	PPACA

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List of Prescription Medications

BIOLOGICALS (Vaccines) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
COVID-19 VACCINES *(cont.)*		
COMIRNATY 2024-2025	T2	PPACA
COMIRNATY 2025-2026 (12Y UP)	T2	PPACA
COMIRNATY 2025-2026(5-11Y)	T2	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T2	PPACA
MNEXSPIKE 2025-2026 (12Y UP)	T2	PPACA
MODERNA COVID (12Y UP)VAC(EUA)	T2	PPACA
MODERNA COVID 23-24(6M-11Y)EUA	T2	PPACA
MODERNA COVID 24-25(6M-11Y)EUA	T2	PPACA
MODERNA COVID BIVAL(6MO UP)EUA	T2	PPACA
MODERNA COVID BIVAL(6MO-5Y)EUA	T2	PPACA
MODERNA COVID(6M-5Y) VACC(EUA)	T2	PPACA
MODERNA COVID-19 BOOSTER (EUA)	T2	PPACA
NOVAVAX COVID 2023-2024 (EUA)	T2	PPACA
NOVAVAX COVID 2024-2025 (EUA)	T2	PPACA
NOVAVAX COVID-19 VACC,ADJ(EUA)	T2	PPACA
NUVAXOVID 2025-2026	T2	PPACA
PFIZER COVID (12Y UP) VAC(EUA)	T2	PPACA
PFIZER COVID (5-11Y) VAC (EUA)	T2	PPACA
PFIZER COVID (6M-4Y) VACC(EUA)	T2	PPACA
PFIZER COVID 2023-24(5-11Y)EUA	T2	PPACA
PFIZER COVID 2023-24(6M-4Y)EUA	T2	PPACA
PFIZER COVID 2024-25(5-11Y)EUA	T2	PPACA
PFIZER COVID 2024-25(6M-4Y)EUA	T2	PPACA
PFIZER COVID BIVAL (12Y UP)EUA	T2	PPACA
PFIZER COVID BIVAL (5-11YR)EUA	T2	PPACA
PFIZER COVID BIVAL (6MO-4Y)EUA	T2	PPACA
PFIZER COVID-19 VACCINE (EUA)	T2	PPACA
SPIKEVAX 2023-2024	T2	PPACA
SPIKEVAX 2024-2025	T2	PPACA
SPIKEVAX 2025-2026 (12Y UP)	T2	PPACA
SPIKEVAX 2025-2026 (6M-11Y)	T2	PPACA
SPIKEVAX COVID (18Y UP) VACC	T2	PPACA

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ENTERIC VIRUS VACCINES		
IPOL	T2	PPACA
ROTARIX	T3	PPACA
ROTATEQ	T3	PPACA
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T2	PPACA
MENACTRA	T2	
MENVEO A-C-Y-W-135-DIP	T2	PPACA
PENBRAYA	T2	PPACA
PENMENVY MEN A-B-C-W-Y	T2	PPACA
TRUMENBA	T2	PPACA
GRAM POSITIVE COCCI VACCINES		
CAPVAXIVE	T2	PPACA
PNEUMOVAX 23	T2	PPACA
PREVNAR 13	T2	
PREVNAR 20	T2	PPACA
VAXNEUVANCE	T2	PPACA
INFLUENZA VIRUS VACCINES		
AFLURIA 2025-2026	T2	
AFLURIA 2025-2026 (3YR UP)	T2	PPACA
AFLURIA QUAD 2022-2023	T2	PPACA
AFLURIA QUAD 2022-23 (3YR UP)	T2	PPACA
AFLURIA QUAD 2023-2024	T2	PPACA
AFLURIA QUAD 2023-24 (3YR UP)	T2	PPACA
AFLURIA TRIV 2024-25 (3YR UP)	T2	PPACA
AFLURIA TRIVALENT 2024-25	T2	PPACA
FLUAD 2025-2026	T2	PPACA
FLUAD QUAD 2022-2023	T2	PPACA
FLUAD QUAD 2023-2024	T2	PPACA
FLUAD TRIVALENT 2024-2025	T2	PPACA
FLUARIX 2025-2026	T2	PPACA
FLUARIX QUAD 2022-2023	T2	PPACA

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INFLUENZA VIRUS VACCINES *(cont.)*		
FLUARIX QUAD 2023-2024	T2	PPACA
FLUARIX TRIVALENT 2024-2025	T2	PPACA
FLUBLOK 2025-2026	T2	PPACA
FLUBLOK QUAD 2022-2023	T2	PPACA
FLUBLOK QUAD 2023-2024	T2	PPACA
FLUBLOK TRIVALENT 2024-2025	T2	PPACA
FLUCELVAX 2025-2026 SYRINGE	T2	PPACA
FLUCELVAX 2025-2026 VIAL	T2	
FLUCELVAX QUAD 2022-2023	T2	PPACA
FLUCELVAX QUAD 2023-2024	T2	PPACA
FLUCELVAX TRIVALENT 2024-2025	T2	PPACA
FLULAVAL 2025-2026	T2	PPACA
FLULAVAL QUAD 2022-2023	T2	PPACA
FLULAVAL QUAD 2023-2024	T2	PPACA
FLULAVAL TRIVALENT 2024-2025	T2	PPACA
FLUMIST 2025-2026	T2	PPACA
FLUMIST HOME 2025-2026	T2	PPACA
FLUMIST QUAD 2022-2023	T2	PPACA
FLUMIST QUAD 2023-2024	T2	PPACA
FLUMIST TRIVALENT 2024-2025	T2	PPACA
FLUZONE 2025-2026 SYRINGE	T2	PPACA
FLUZONE 2025-2026 VIAL	T2	
FLUZONE HIGH-DOSE 2025-2026	T2	PPACA
FLUZONE HIGH-DOSE QUAD 2022-23	T2	PPACA
FLUZONE HIGH-DOSE QUAD 2023-24	T2	PPACA
FLUZONE HIGH-DOSE TRIV 2024-25	T2	PPACA
FLUZONE QUAD 2022-2023	T2	PPACA
FLUZONE QUAD 2023-2024	T2	PPACA
FLUZONE TRIVALENT 2024-2025	T2	PPACA
NEUROTOXIC VIRUS VACCINES		
DENGVAXIA	T2	PPACA
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
BCG VACCINE (TICE STRAIN)	T2	SP

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BIOLOGICALS (Vaccines) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T2	PPACA
ADACEL TDAP	T2	PPACA
BOOSTRIX TDAP	T2	PPACA
DAPTACEL DTAP	T2	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T2	
HIBERIX	T2	PPACA
INFANRIX DTAP	T2	PPACA
KINRIX	T2	PPACA
M-M-R II VACCINE	T2	PPACA
PEDVAXHIB	T2	PPACA
PENTACEL	T2	PPACA
PENTACEL ACTHIB COMPONENT	T2	PPACA
PRIORIX	T2	PPACA
PROQUAD	T2	PPACA
QUADRACEL DTAP-IPV	T2	PPACA
TDVAX	T2	PPACA
TENIVAC	T2	PPACA
VAXELIS	T2	PPACA
VIRAL/TUMORIGENIC VACCINES		
ABRYSVO	T3	PPACA
ACAM2000 (NATIONAL STOCKPILE)	T3	
AREXVY	T3	PPACA
ENGERIX-B ADULT	T2	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T2	PPACA
ERVEBO (NATIONAL STOCKPILE)	T3	
GARDASIL 9	T2	PPACA
HEPLISAV-B	T2	PPACA
JYNNEOS	T3	
JYNNEOS (NATIONAL STOCKPILE)	T3	
MRESVIA	T3	PPACA
PEDIARIX	T2	PPACA
PREHEVBRIO	T2	PPACA

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BIOLOGICALS (Vaccines) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VIRAL/TUMORIGENIC VACCINES *(cont.)*		
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	QL(2 KITS/720 DAYS) PPACA
TWINRIX	T2	PPACA
VARIVAX VACCINE	T2	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
CABLIVI	T3	PA SP
ANTI-FIBRINOLYTIC AGENTS		
AMICAR (*aminocaproic acid*)	T3	SP HD
aminocaproic acid (Amicar)	T1	SP HD
tranexamic acid (Lysteda)	T1	SP
ANTI-HEMOPHILIC FACTORS		
ADVATE	T3	PA SP HD
ADYNOVATE	T2	PA SP HD
AFSTYLA	T2	PA SP HD
ALPHANATE	T3	PA SP HD
ALTUVIIIO	T2	PA SP HD
ELOCTATE	T2	PA SP HD
ESPEROCT	T2	PA SP HD
HEMOFIL M	T3	PA SP HD
HUMATE-P	T3	PA SP HD
JIVI	T2	PA SP HD
KOATE	T3	PA SP HD
KOGENATE FS	T2	PA SP HD
KOVALTRY	T2	PA SP HD
NOVOEIGHT	T2	PA SP HD
NUWIQ	T3	PA SP HD
RECOMBINATE	T3	PA SP HD
WILATE	T3	PA SP HD
XYNTHA	T3	PA SP HD
XYNTHA SOLOFUSE	T3	PA SP HD

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BLOOD (Blood Modifiers/Bleeding Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
COMPLEMENT INHIBITORS		
EMPAVELI	T2	PA SP
FABHALTA	T2	PA QL(2 CAPS/DAY) SP
TAVNEOS	T3	PA QL(6 CAPS/DAY) SP
VOYDEYA	T2	PA QL(1 PACKET/28 Days) SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
ALHEMO PEN	T2	PA SP
HEMLIBRA	T2	PA SP HD
HYMPAVZI PEN	T2	PA SP
PYRUVATE KINASE ACTIVATORS		
PYRUKYND 20 MG TABLET	T3	PA QL(2 TABS/DAY) SP
PYRUKYND 20-5 MG TAPER PACK	T3	PA QL(2 PACKS/270 DAYS) SP
PYRUKYND 5 MG TABLET	T3	PA QL(2 TABS/DAY) SP
PYRUKYND 5 MG TAPER PACK	T3	PA QL(2 PACKS/270 DAYS) SP
PYRUKYND 50 MG TABLET	T3	PA QL(2 TABS/DAY) SP
PYRUKYND 50-20 MG TAPER PACK	T3	PA QL(2 PACKS/270 DAYS) SP
SICKLE CELL ANEMIA AGENTS		
DROXIA	T2	
SIKLOS	T3	PA
TOPICAL HEMOSTATICS		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
gelatin sponge, absorb/porcine (Gelfoam)	T1	
GELFOAM	T3	
GELFOAM (*gelatin sponge,absorb/porcine*)	T3	
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RAPLIXA	T3	
RECOTHROM	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
THROMBI-GEL	T3	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD (Blood Modifiers/Bleeding Disorders) *(cont.)*		
TOPICAL HEMOSTATICS *(cont.)*		
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
BLOOD (Blood Thinners/Anti-Clotting)		
HEMORRHEOLOGIC AGENTS		
pentoxifylline	T1	HD
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
ranolazine	T1	QL (4 TABS/DAY) HD
ranolazine (Ranexa)	T1	QL (4 TABS/DAY) HD
ANTI-ARRHYTHMICS		
amiodarone hcl	T1	HD
disopyramide phosphate (Norpace)	T1	HD
dofetilide 125 mcg capsule (Tikosyn)	T1	QL(8 CAPS/DAY) HD
dofetilide 250 mcg capsule (Tikosyn)	T1	QL(4 CAPS/DAY) HD
dofetilide 500 mcg capsule (Tikosyn)	T1	QL(2 CAPS/DAY) HD
flecainide acetate	T1	HD
mexiletine hcl	T1	HD
MULTAQ	T2	HD
NORPACE (*disopyramide phosphate*)	T3	PA HD
NORPACE CR	T3	HD
pacerone 100 mg tablet	T3	PA HD
pacerone 200 mg tablet	T1	HD
pacerone 400 mg tablet	T3	PA HD
propafenone hcl	T1	HD
quinidine gluconate	T1	HD
quinidine sulfate	T1	HD
RYTHMOL SR (*propafenone hcl er*)	T3	PA HD
TIKOSYN 125 MCG CAPSULE (*dofetilide*)	T3	PA QL (8 CAPS/DAY) HD
TIKOSYN 250 MCG CAPSULE (*dofetilide*)	T3	PA QL (4 CAPS/DAY) HD
TIKOSYN 500 MCG CAPSULE (*dofetilide*)	T3	PA QL (2 CAPS/DAY) HD

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CARDIAC DRUGS (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CALCIUM CHANNEL BLOCKING AGENTS		
amlodipine besylate (Norvasc)	T1	HD
CALAN SR (*verapamil er*)	T3	HD
diltiazem 24h er(la) 120 mg tb (Cardizem La)	T1	QL(1 TAB/DAY) HD
diltiazem 24h er(la) 180 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 240 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 300 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 360 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 420 mg tb (Cardizem La)	T1	HD
diltiazem hcl	T1	HD
diltiazem hcl (Cardizem Cd)	T1	HD
diltiazem hcl (Cardizem La)	T1	HD
diltiazem hcl (Cardizem)	T1	HD
diltiazem hcl (Tiazac)	T1	HD
felodipine	T1	HD
isradipine	T1	
nicardipine hcl	T1	HD
nifedipine	T1	HD
nifedipine (Procardia Xl)	T1	HD
nimodipine 30 mg capsule	T1	HD
nimodipine 60 mg/20 ml soln	T1	
nisoldipine er 17 mg tablet (Sular)	T1	HD
nisoldipine er 20 mg tablet	T1	QL(1 TAB/DAY) HD
nisoldipine er 25.5 mg tablet	T1	HD
nisoldipine er 30 mg tablet	T1	HD
nisoldipine er 34 mg tablet (Sular)	T1	HD
nisoldipine er 40 mg tablet	T1	HD
nisoldipine er 8.5 mg tablet (Sular)	T1	HD
NORLIQVA	T2	QL(1 TAB/DAY) HD
NYMALIZE	T3	
SULAR (*nisoldipine*)	T3	HD
TIAZAC (*diltiazem hcl*)	T3	HD
verapamil hcl	T1	HD

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CARDIAC DRUGS (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CALCIUM CHANNEL BLOCKING AGENTS *(cont.)*		
verapamil hcl (Calan Sr)	T1	HD
verapamil hcl (Verelan Pm)	T1	HD
verapamil hcl (Verelan)	T1	HD
VERELAN (*verapamil hcl*)	T3	HD
VERELAN PM (*verapamil hcl*)	T3	HD
CARDIAC MYOSIN INHIBITOR		
CAMZYOS	T3	PA QL(1 CAP/DAY) SP HD
DIGITALIS GLYCOSIDES		
digoxin (Lanoxin)	T1	HD
digoxin 0.05 mg/ml solution	T1	HD
digoxin 0.125 mg tablet (Lanoxin)	T1	HD
digoxin 0.25 mg tablet (Lanoxin)	T1	HD
digoxin 125 mcg tablet (Lanoxin)	T1	HD
digoxin 250 mcg tablet (Lanoxin)	T1	HD
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.		
CORLANOR 5 MG/5 ML ORAL SOLN	T2	PA SP HD
ivabradine hcl (Corlanor)	T1	PA HD
VASODILATORS, CORONARY		
isosorbide dinitrate 10 mg tab	T1	HD
isosorbide dinitrate 20 mg tab	T1	HD
isosorbide dinitrate 30 mg tab	T1	HD
isosorbide dinitrate 5 mg tab (Isordil Titradose)	T1	HD
isosorbide mononitrate	T1	HD
NITRO-DUR	T3	HD
nitroglycerin	T1	HD
nitroglycerin 0.3 mg tablet sl (Nitrostat)	T1	HD
nitroglycerin 0.4 mg tablet sl (Nitrostat)	T1	HD
nitroglycerin 0.6 mg tablet sl (Nitrostat)	T1	HD
nitroglycerin 400 mcg spray (Nitrolingual)	T1	HD
NITROLINGUAL (*nitroglycerin*)	T3	HD
NITROMIST (*nitroglycerin*)	T3	HD
NITROSTAT (*nitroglycerin*)	T3	HD

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List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T2	PA SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
sildenafil 10 mg/ml oral susp (Revatio)	T1	PA SP HD
sildenafil 20 mg tablet (Revatio)	T1	PA SP HD
tadalafil (Adcirca)	T1	PA SP HD
tadalafil 20 mg tablet (Adcirca)	T1	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
ambrisentan (Letairis)	T1	PA SP HD
bosentan (Tracleer)	T1	PA SP HD
OPSUMIT	T2	PA SP HD
TRACLEER 125 MG TABLET (*bosentan*)	T3	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP *(bosentan)*	T2	PA SP HD
TRACLEER 62.5 MG TABLET (*bosentan*)	T3	PA SP HD
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T3	PA SP HD
WINREVAIR (2 PACK)	T3	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM ER	T3	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T3	PA QL(168 TABS/180 DAYS) SP HD
ORENITRAM MONTH 2 TITRATION KT	T3	PA QL(336 TABS/180 DAYS) SP HD
ORENITRAM MONTH 3 TITRATION KT	T3	PA QL(252 TABS/180 DAYS) SP HD
TYVASO	T3	PA SP HD
TYVASO DPI	T2	PA SP HD
TYVASO INSTITUTIONAL START KIT	T3	PA SP HD
TYVASO REFILL KIT	T3	PA SP HD
TYVASO STARTER KIT	T3	PA SP HD
UPTRAVI	T2	PA SP HD
VENTAVIS	T2	PA SP HD
PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH		
OPSYNVI	T2	PA QL(1 TAB/DAY) SP HD
CARDIOVASCULAR (Blood Pressure/Heart Medications)		
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
amlodipine besylate/benazepril	T1	HD
amlodipine besylate/benazepril (Lotrel)	T1	HD

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION *(cont.)*		
PRESTALIA 14 MG-10 MG TABLET	T3	HD
PRESTALIA 3.5 MG-2.5 MG TABLET	T3	QL (1 TAB/DAY) HD
PRESTALIA 7 MG-5 MG TABLET	T3	QL (1 TAB/DAY) HD
trandolapril/verapamil hcl	T1	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
benazepril/hydrochlorothiazide	T1	HD
benazepril/hydrochlorothiazide (Lotensin Hct)	T1	HD
captopril-hctz 25-15 mg tablet	T1	QL(3 TABS/DAY) HD
captopril-hctz 25-25 mg tablet	T1	QL(2 TABS/DAY) HD
captopril-hctz 50-15 mg tablet	T1	QL(3 TABS/DAY) HD
captopril-hctz 50-25 mg tablet	T1	QL(2 TABS/DAY) HD
enalapril/hydrochlorothiazide	T1	HD
enalapril/hydrochlorothiazide (Vaseretic)	T1	HD
fosinopril/hydrochlorothiazide	T1	HD
lisinopril/hydrochlorothiazide (Zestoretic)	T1	HD
quinapril/hydrochlorothiazide (Accuretic)	T1	HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
carvedilol (Coreg)	T1	HD
carvedilol er 10 mg capsule (Coreg Cr)	T1	QL(1 CAP/DAY) HD
carvedilol er 20 mg capsule (Coreg Cr)	T1	QL(1 CAP/DAY) HD
carvedilol er 40 mg capsule (Coreg Cr)	T1	QL(1 CAP/DAY) HD
carvedilol er 80 mg capsule (Coreg Cr)	T1	HD
labetalol hcl 100 mg tablet	T1	HD
labetalol hcl 200 mg tablet	T1	HD
labetalol hcl 300 mg tablet	T1	HD
LABETALOL HCL 400 MG TABLET	T3	HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
CARDURA XL	T3	HD
doxazosin mesylate (Cardura)	T1	HD
MINIPRESS	T3	HD
prazosin hcl	T1	HD
prazosin hcl (Minipress)	T1	HD
terazosin hcl	T1	HD

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CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
amlodipine/valsartan/hcthiazid (Exforge Hct)	T1	HD
olmesartan/amlodipin/hcthiazid (Tribenzor)	T1	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO SPRINKLE	T2	HD
sacubitril/valsartan (Entresto)	T1	QL(2 TABS/DAY) HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
candesartan/hydrochlorothiazid (Atacand Hct)	T1	HD
irbesartan/hydrochlorothiazide (Avalide)	T1	HD
losartan/hydrochlorothiazide (Hyzaar)	T1	HD
olmesartan-hctz 20-12.5 mg tab (Benicar Hct)	T1	QL(1 TAB/DAY) HD
olmesartan-hctz 40-12.5 mg tab (Benicar Hct)	T1	HD
olmesartan-hctz 40-25 mg tab (Benicar Hct)	T1	HD
telmisartan-hctz 40-12.5 mg tb (Micardis Hct)	T1	QL(1 TAB/DAY) HD
telmisartan-hctz 80-12.5 mg tb (Micardis Hct)	T1	HD
telmisartan-hctz 80-25 mg tab (Micardis Hct)	T1	HD
valsartan/hydrochlorothiazide (Diovan Hct)	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
amlodipine besylate/valsartan (Exforge)	T1	HD
amlodipine-olmesartan 10-20 mg (Azor)	T1	HD
amlodipine-olmesartan 10-40 mg (Azor)	T1	HD
amlodipine-olmesartan 5-20 mg (Azor)	T1	QL(1 TAB/DAY) HD
amlodipine-olmesartan 5-40 mg (Azor)	T1	HD
telmisartan-amlodipine 40-10	T1	HD
telmisartan-amlodipine 40-5 mg	T1	QL(1 TAB/DAY) HD
telmisartan-amlodipine 80-10	T1	HD
telmisartan-amlodipine 80-5 mg	T1	HD
ANTI-HYPERTENSIVES, ACE INHIBITORS		
benazepril hcl	T1	HD
benazepril hcl (Lotensin)	T1	HD
captopril	T1	HD
enalapril maleate (Epaned)	T1	HD
enalapril maleate (Vasotec)	T1	HD
fosinopril sodium	T1	HD

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CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERTENSIVES, ACE INHIBITORS *(cont.)*		
lisinopril (Zestril)	T1	HD
moexipril hcl	T1	HD
perindopril erbumine	T1	HD
quinapril hcl (Accupril)	T1	HD
ramipril	T1	HD
ramipril (Altace)	T1	HD
trandolapril	T1	HD
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
candesartan cilexetil (Atacand)	T1	HD
eprosartan mesylate	T1	HD
irbesartan	T1	HD
irbesartan (Avapro)	T1	HD
losartan potassium (Cozaar)	T1	HD
olmesartan medoxomil 20 mg tab (Benicar)	T1	QL(1 TAB/DAY) HD
olmesartan medoxomil 40 mg tab (Benicar)	T1	HD
olmesartan medoxomil 5 mg tab (Benicar)	T1	HD
telmisartan 20 mg tablet	T1	QL(1 TAB/DAY) HD
telmisartan 40 mg tablet (Micardis)	T1	QL(1 TAB/DAY) HD
telmisartan 80 mg tablet (Micardis)	T1	HD
valsartan 160 mg tablet (Diovan)	T1	HD
valsartan 20 mg/5 ml solution	T1	HD
valsartan 320 mg tablet (Diovan)	T1	HD
valsartan 40 mg tablet (Diovan)	T1	HD
valsartan 80 mg tablet (Diovan)	T1	HD
ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T1	
ANTI-HYPERTENSIVES, MISCELLANEOUS		
metyrosine (Demser)	T1	PA HD
ANTI-HYPERTENSIVES, SYMPATHOLYTIC		
clonidine (Catapres-tts 1)	T1	HD
clonidine (Catapres-tts 2)	T1	HD
clonidine (Catapres-tts 3)	T1	HD
clonidine hcl	T1	HD

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CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERTENSIVES, SYMPATHOLYTIC *(cont.)*		
guanfacine hcl	T1	HD
methyldopa	T1	HD
methyldopa/hydrochlorothiazide	T1	HD
ANTI-HYPERTENSIVES, VASODILATORS		
hydralazine hcl	T1	HD
minoxidil	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol hcl	T1	HD
atenolol (Tenormin)	T1	HD
betaxolol hcl	T1	HD
bisoprolol fumarate 10 mg tab	T1	HD
bisoprolol fumarate 5 mg tab	T1	HD
metoprolol succinate (Toprol Xl)	T1	HD
metoprolol tartrate	T1	HD
metoprolol tartrate (Lopressor)	T1	HD
nadolol	T1	HD
nebivolol 10 mg tablet (Bystolic)	T1	HD
nebivolol 2.5 mg tablet (Bystolic)	T1	HD
nebivolol 20 mg tablet (Bystolic)	T1	HD
nebivolol 5 mg tablet (Bystolic)	T1	HD
pindolol	T1	HD
propranolol hcl	T1	HD
propranolol hcl (Inderal La)	T1	HD
sotalol hcl (Betapace Af)	T1	HD
sotalol hcl (Betapace)	T1	HD
SOTYLIZE	T3	HD
timolol maleate	T1	HD
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
atenolol/chlorthalidone (Tenoretic 100)	T1	HD
atenolol/chlorthalidone (Tenoretic 50)	T1	HD
bisoprolol/hydrochlorothiazide	T1	HD
metoprolol/hydrochlorothiazide	T1	HD
propranolol/hydrochlorothiazid	T1	HD

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
RENIN INHIBITOR, DIRECT		
*aliskiren 150 mg tablet (*Tekturna*)*	T1	QL(1 TAB/DAY) HD
*aliskiren 300 mg tablet (*Tekturna*)*	T1	HD
VASODILATORS, COMBINATION		
isosorbide-hydralazine 20-37.5 (Bidil)	T1	QL(6 TABS/DAY) HD
VASODILATORS, PERIPHERAL		
ergoloid mesylates	T1	
isoxsuprine hcl	T1	
CARDIOVASCULAR (Cholesterol Medications)		
ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
*ezetimibe/simvastatin (*Vytorin*)*	T1	HD
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
amlodipine-atorvast 10-10 mg (Caduet)	T1	HD
amlodipine-atorvast 10-20 mg (Caduet)	T1	HD
amlodipine-atorvast 10-40 mg (Caduet)	T1	HD
amlodipine-atorvast 10-80 mg (Caduet)	T1	HD
amlodipine-atorvast 2.5-10 mg	T1	HD
amlodipine-atorvast 2.5-20 mg	T1	QL(1 TAB/DAY) HD
amlodipine-atorvast 2.5-40 mg	T1	QL(1 TAB/DAY) HD
amlodipine-atorvast 5-10 mg (Caduet)	T1	HD
amlodipine-atorvast 5-20 mg (Caduet)	T1	QL(1 TAB/DAY) HD
amlodipine-atorvast 5-40 mg (Caduet)	T1	QL(1 TAB/DAY) HD
amlodipine-atorvast 5-80 mg (Caduet)	T1	HD
CADUET 5 MG-10 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 5 MG-20 MG TABLET (*amlodipine-atorvastatin*)	T3	QL(1 TAB/DAY) HD
CADUET 5 MG-40 MG TABLET (*amlodipine-atorvastatin*)	T3	QL(1 TAB/DAY) HD
CADUET 5 MG-80 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-10 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-20 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-40 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-80 MG TABLET (*amlodipine-atorvastatin*)	T3	HD

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T3	PA QL(1 AUTO-INJ/28 DAYS) SP
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA PUSHTRONEX	T2	
REPATHA SURECLICK	T2	
REPATHA SYRINGE	T2	
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins)		
atorvastatin 10 mg tablet	T1	HD PPACA
atorvastatin 20 mg tablet	T1	HD PPACA
atorvastatin 40 mg tablet	T1	HD
atorvastatin 80 mg tablet	T1	HD
fluvastatin sodium	T1	HD PPACA
fluvastatin sodium (Lescol Xl)	T1	HD PPACA
lovastatin 10 mg tablet	T1	HD
lovastatin 20 mg tablet	T1	HD PPACA
lovastatin 40 mg tablet	T1	HD PPACA
pitavastatin 1 mg tablet (Livalo)	T1	QL(1 TAB/DAY) HD PPACA
pitavastatin 2 mg tablet (Livalo)	T1	QL(1 TAB/DAY) HD PPACA
pitavastatin 4 mg tablet (Livalo)	T1	HD PPACA
pravastatin sodium	T1	HD PPACA
rosuvastatin calcium 10 mg tab (Crestor)	T1	QL(1 TAB/DAY) HD PPACA
rosuvastatin calcium 20 mg tab (Crestor)	T1	QL(1 TAB/DAY) HD
rosuvastatin calcium 40 mg tab (Crestor)	T1	HD
rosuvastatin calcium 5 mg tab (Crestor)	T1	QL(1 TAB/DAY) HD PPACA
simvastatin 10 mg tablet (Zocor)	T1	HD PPACA
simvastatin 20 mg tablet (Zocor)	T1	HD PPACA
simvastatin 40 mg tablet (Zocor)	T1	HD PPACA
simvastatin 5 mg tablet	T1	HD
simvastatin 80 mg tablet	T1	QL(1 TAB/DAY) HD
BILE SALT SEQUESTRANTS		
cholestyramine	T1	HD
cholestyramine (Questran Light)	T1	HD
cholestyramine (with sugar) (Questran)	T1	HD

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CARDIOVASCULAR (Cholesterol Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BILE SALT SEQUESTRANTS *(cont.)*		
cholestyramine/aspartame	T1	HD
colesevelam hcl (Welchol)	T1	HD
COLESTID	T3	HD
COLESTID (*colestipol hcl*)	T3	HD
colestipol hcl	T1	HD
colestipol hcl (Colestid)	T1	HD
QUESTRAN (*cholestyramine*)	T3	HD
QUESTRAN LIGHT (*prevalite*)	T3	HD
LIPOTROPICS		
ezetimibe (Zetia)	T1	HD
fenofibrate 120 mg tablet (Fenoglide)	T1	HD
fenofibrate 130 mg capsule	T1	HD
fenofibrate 134 mg capsule	T1	HD
fenofibrate 145 mg tablet (Tricor)	T1	HD
FENOFIBRATE 150 MG CAPSULE	T1	HD
fenofibrate 160 mg tablet	T1	HD
fenofibrate 200 mg capsule	T1	HD
fenofibrate 40 mg tablet (Fenoglide)	T1	HD
fenofibrate 43 mg capsule	T1	HD
fenofibrate 48 mg tablet (Tricor)	T1	HD
FENOFIBRATE 50 MG CAPSULE	T1	HD
fenofibrate 54 mg tablet	T1	HD
fenofibrate 67 mg capsule	T1	HD
fenofibric acid	T1	HD
fenofibric acid (*choline*)	T1	HD
fenofibric acid (Fibricor)	T1	HD
FIBRICOR (*fenofibric acid*)	T3	ST HD
gemfibrozil (Lopid)	T1	HD
LIPOFEN	T3	ST HD
LOPID (*gemfibrozil*)	T1	HD
niacin	T3	ST HD
TRICOR *(fenofibrate nanocrystallized)*	T3	ST HD

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CARDIOVASCULAR (Cholesterol Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST		
FILSPARI	T2	PA QL(1 TAB/DAY) SP
CNS DRUGS (Alzheimer's Disease)		
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
memantine hcl	T1	HD
MEMANTINE HCL	T1	HD
memantine hcl er 14 mg capsule (Namenda Xr)	T1	QL(1 CAP/DAY) HD
memantine hcl er 21 mg capsule	T1	HD
memantine hcl er 28 mg capsule (Namenda Xr)	T1	HD
memantine hcl er 7 mg capsule (Namenda Xr)	T1	QL(1 CAP/DAY) HD
NAMENDA	T3	HD
NAMENDA XR TITRATION PACK	T3	QL(112 CAPS/365 DAYS) HD
ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB		
memantine hcl/donepezil hcl (Namzaric)	T1	QL(2 CAPS/DAY) HD
CNS DRUGS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
RADICAVA ORS 105 MG/5 ML SUSP	T3	PA QL(50 MLS/30 DAYS) SP HD
RADICAVA ORS STARTER KIT SUSP	T3	PA QL(70 MLS/365 DAYS) SP HD
riluzole (Rilutek)	T1	SP HD
TEGLUTIK	T3	PA SP
TIGLUTIK	T3	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO XR 12 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 18 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 24 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD
AUSTEDO XR 30 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 36 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 42 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 48 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 6 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T3	PA QL(1 KIT/180 DAYS) SP HD
INGREZZA	T3	PA QL(1 CAP/DAY) SP

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CNS DRUGS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUGS TO TREAT MOVEMENT DISORDERS *(cont.)*		
INGREZZA INITIATION PK(TARDIV)	T3	PA QL(28 CAPS/365 DAYS) SP
INGREZZA SPRINKLE	T3	PA QL(1 CAP/DAY) SP
tetrabenazine (Xenazine)	T1	PA SP HD
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T3	QL(4 CAPS/DAY)
XANTHINES		
caffeine citrate	T1	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AVONEX (4 PACK)	T2	PA SP HD
AVONEX PEN (4 PACK)	T2	PA SP HD
BAFIERTAM	T2	PA SP HD
BETASERON	T2	PA SP HD
cladribine	T1	PA SP HD
dimethyl fumarate 30d start pk (Tecfidera)	T1	SP HD
dimethyl fumarate dr 120 mg cp (Tecfidera)	T1	SP HD
dimethyl fumarate dr 240 mg cp (Tecfidera)	T1	SP HD
fingolimod hcl (Gilenya)	T1	SP HD
glatiramer acetate (Copaxone)	T1	SP HD
KESIMPTA PEN	T2	PA SP HD
MAVENCLAD	T3	PA SP HD
MAYZENT	T2	PA SP HD
PLEGRIDY	T2	PA SP HD
PLEGRIDY PEN	T2	PA SP HD
REBIF	T2	PA SP HD
REBIF REBIDOSE	T2	PA SP HD
teriflunomide (Aubagio)	T1	SP HD
VUMERITY	T2	PA SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
dalfampridine er 10 mg tablet (Ampyra)	T1	PA SP HD
FIRDAPSE	T3	PA QL(8 TABS/DAY) SP

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List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SPHINGOSINE 1-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA	T2	PA SP HD
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY SYRINGE	T2	PA
POSTHERPETIC NEURALGIA AGENTS		
gabapentin (Gralise)	T1	
GRALISE ER 300 MG TABLET *(gabapentin)*	T3	
GRALISE ER 600 MG TABLET *(gabapentin)*	T3	
SPHINGOSINE 1-PHOSPHATE (SIP) RECEPTOR MODULATOR		
VELSIPITY	T2	PA QL(30 TABS/30 DAYS) SP HD
ZEPOSIA	T2	PA SP HD
CNS DRUGS (Seizure Disorders)		
ANTI-CONVULSANT - BENZODIAZEPINE TYPE		
clobazam (Onfi)	T1	HD
clonazepam	T1	HD
clonazepam (Klonopin)	T1	HD
DIASTAT (*diazepam*)	T3	PA HD
diazepam 10 mg rectal gel syrg	T1	HD
diazepam 10mg rectal gel (2pk)	T1	HD
diazepam 2.5mg rectal gel(2pk) (Diastat)	T1	HD
diazepam 20 mg rectal gel syrg	T1	HD
diazepam 20mg rectal gel (2pk)	T1	HD
KLONOPIN (*clonazepam*)	T3	PA HD
NAYZILAM	T2	PA QL(10 UNITS/30 DAYS) HD
VALTOCO	T2	PA QL(10 BLISTER PACKS/30 DAYS) HD
ANTI-CONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T3	PA SP HD
BRIVIACT	T3	PA HD
carbamazepine (Carbatrol)	T1	HD
carbamazepine (Tegretol Xr)	T1	HD
carbamazepine (Tegretol)	T1	HD
carbamazepine 100 mg tab chew	T1	HD
carbamazepine 100 mg/5 ml cup	T1	HD

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS *(cont.)*		
carbamazepine 100 mg/5 ml susp (Tegretol)	T1	HD
CARBAMAZEPINE 200 MG TAB CHEW	T3	HD
carbamazepine 200 mg tablet (Tegretol)	T1	HD
carbamazepine 200 mg/10 ml cup	T1	HD
CARBATROL (*carbamazepine*)	T3	PA HD
CELONTIN (*methsuximide*)	T3	HD
DIACOMIT	T3	PA SP HD
DILANTIN 100 MG CAPSULE *(phenytoin sodium extended)*	T3	PA HD
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB *(phenytoin)*	T3	PA HD
DILANTIN-125 *(phenytoin)*	T3	PA HD
divalproex sodium (Depakote Er)	T1	HD
divalproex sodium (Depakote Sprinkle)	T1	HD
divalproex sodium (Depakote)	T1	HD
eslicarbazepine 200 mg tablet (Aptiom)	T1	PA QL(1 TAB/DAY) HD
eslicarbazepine 400 mg tablet (Aptiom)	T1	PA QL(1 TAB/DAY) HD
eslicarbazepine 600 mg tablet (Aptiom)	T1	PA HD
eslicarbazepine 800 mg tablet (Aptiom)	T1	PA HD
ethosuximide (Zarontin)	T1	HD
felbamate (Felbatol)	T1	HD
FINTEPLA	T3	PA SP HD
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
gabapentin	T1	HD
gabapentin (Neurontin)	T1	HD
lacosamide (Vimpat)	T1	HD
lamotrigine (Lamictal (Blue))	T1	HD
lamotrigine (Lamictal (Green))	T1	HD
lamotrigine (Lamictal (Orange))	T1	HD
lamotrigine (Lamictal Odt (Blue))	T1	HD
lamotrigine (Lamictal Odt (Green))	T1	HD

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CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS *(cont.)*		
lamotrigine (Lamictal Odt (Orange))	T1	HD
lamotrigine (Lamictal Odt)	T1	HD
lamotrigine (Lamictal Xr)	T1	HD
lamotrigine (Lamictal)	T1	HD
levetiracetam (Keppra Xr)	T1	HD
levetiracetam (Keppra)	T1	HD
levetiracetam 1,000 mg tablet (Keppra)	T1	HD
levetiracetam 1,000mg/10ml cup (Keppra)	T1	HD
levetiracetam 100 mg/ml soln (Keppra)	T1	HD
LEVETIRACETAM 250 MG TAB SUSP	T3	PA HD
levetiracetam 250 mg tablet (Keppra)	T1	HD
levetiracetam 500 mg tablet (Keppra)	T1	HD
levetiracetam 500 mg/5 ml cup	T1	HD
levetiracetam 500 mg/5 ml soln	T1	HD
levetiracetam 750 mg tablet (Keppra)	T1	HD
LYRICA 20 MG/ML ORAL SOLUTION *(pregabalin)*	T3	PA HD
methsuximide (Celontin)	T1	HD
NEURONTIN 400 MG CAPSULE *(gabapentin)*	T3	HD
NEURONTIN 600 MG TABLET *(gabapentin)*	T3	HD
NEURONTIN 800 MG TABLET *(gabapentin)*	T3	HD
oxcarbazepine (Oxtellar Xr)	T1	PA HD
oxcarbazepine (Trileptal)	T1	HD
OXTELLAR XR *(oxcarbazepine)*	T3	PA HD
perampanel 10 mg tablet (Fycompa)	T1	PA HD
perampanel 12 mg tablet (Fycompa)	T1	PA HD
perampanel 2 mg tablet (Fycompa)	T1	PA HD
perampanel 4 mg tablet (Fycompa)	T1	PA QL(1 TAB/DAY) HD
perampanel 6 mg tablet (Fycompa)	T1	PA QL(1 TAB/DAY) HD
perampanel 8 mg tablet (Fycompa)	T1	PA HD
PHENYTEK *(phenytoin sodium extended)*	T3	PA HD

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CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS *(cont.)*		
phenytoin	T1	HD
phenytoin (Dilantin)	T1	HD
phenytoin (Dilantin-125)	T1	HD
phenytoin sodium extended (Dilantin)	T1	HD
phenytoin sodium extended (Phenytek)	T1	HD
pregabalin (Lyrica)	T1	HD
primidone 250 mg tablet (Mysoline)	T1	HD
primidone 50 mg tablet (Mysoline)	T1	HD
rufinamide 200 mg tablet (Banzel)	T1	PA QL(16 TABS/DAY) HD
rufinamide 40 mg/ml suspension (Banzel)	T1	PA QL(80 MLS/DAY) HD
rufinamide 400 mg tablet (Banzel)	T1	PA QL(8 TABS/DAY) HD
SPRITAM	T3	PA HD
subvenite 100 mg tablet (Lamictal)	T1	HD
subvenite 150 mg tablet (Lamictal)	T1	HD
subvenite 200 mg tablet (Lamictal)	T1	HD
subvenite 25 mg tablet (Lamictal)	T1	HD
TEGRETOL *(carbamazepine)*	T3	PA HD
TEGRETOL XR *(carbamazepine)*	T3	PA HD
tiagabine hcl 12 mg tablet	T1	QL(8 TABS/DAY) HD
tiagabine hcl 16 mg tablet	T1	QL(6 TABS/DAY) HD
tiagabine hcl 2 mg tablet	T1	HD
tiagabine hcl 4 mg tablet	T1	HD
topiramate (Qudexy Xr)	T1	HD
topiramate 100 mg tablet (Topamax)	T1	HD
topiramate 15 mg sprinkle cap (Topamax)	T1	HD
topiramate 200 mg tablet (Topamax)	T1	HD
topiramate 25 mg sprinkle cap (Topamax)	T1	HD
topiramate 25 mg tablet (Topamax)	T1	HD
topiramate 25 mg/ml solution (Eprontia)	T1	HD
topiramate 50 mg sprinkle cap	T1	HD

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS *(cont.)*		
*topiramate 50 mg tablet (*Topamax*)*	T1	HD
topiramate er 100 mg capsule (Trokendi Xr)	T1	QL(1 CAP/DAY) HD
topiramate er 200 mg capsule (Trokendi Xr)	T1	HD
topiramate er 25 mg capsule (Trokendi Xr)	T1	QL(1 CAP/DAY) HD
topiramate er 50 mg capsule (Trokendi Xr)	T1	HD
TROKENDI XR 100 MG CAPSULE (*topiramate*)	T3	QL(1 CAP/DAY) HD
TROKENDI XR 200 MG CAPSULE (*topiramate*)	T3	HD
TROKENDI XR 25 MG CAPSULE (*topiramate*)	T3	QL(1 CAP/DAY) HD
TROKENDI XR 50 MG CAPSULE (*topiramate*)	T3	HD
valproic acid	T1	HD
valproic acid (as sodium salt)	T1	HD
*vigabatrin (*Sabril*)*	T1	SP HD
*vigadrone 500 mg powder packet (*Sabril*)*	T1	SP HD
VIMPAT 10 MG/ML SOLUTION *(lacosamide)*	T2	HD
XCOPRI 100 MG TABLET	T3	PA QL(1 TABLET/DAY) HD
XCOPRI 12.5-25 MG TITRATION PK	T3	PA QL(28 TABS/28 DAYS) HD
XCOPRI 150 MG TABLET	T3	PA QL(1 TABLET/DAY) HD
XCOPRI 150-200 MG TITRATION PK	T3	PA QL(28 TABS/28 DAYS) HD
XCOPRI 200 MG TABLET	T3	PA QL(2 TABS/DAY) HD
XCOPRI 25 MG TABLET	T3	PA QL(1 TABLET/DAY) HD
XCOPRI 250 MG DAILY DOSE PACK	T3	PA QL(56 TABS/28 DAYS) HD
XCOPRI 350 MG DAILY DOSE PACK	T3	PA QL(56 TABS/28 DAYS) HD
XCOPRI 50 MG TABLET	T3	PA QL(1 TABLET/DAY) HD
XCOPRI 50-100 MG TITRATION PAK	T3	PA QL(28 TABS/28 DAYS) HD
ZARONTIN *(ethosuximide)*	T3	PA HD
zonisamide	T1	HD
*zonisamide (*Zonegran*)*	T1	HD
CNS DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX	T3	PA QL(2 TABS/DAY) SP HD

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COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ERYTHROPOIESIS-STIMULATING AGENTS		
ARANESP	T2	PA SP
EPOGEN	T2	PA SP
MIRCERA	T3	PA SP
PROCRIT	T2	PA SP
RETACRIT	T2	PA SP
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T3	PA SP
FYLNETRA	T3	PA SP
GRANIX	T3	PA SP
LEUKINE	T2	SP
NEULASTA	T2	PA SP
NEULASTA ONPRO	T2	PA SP HD
NEUPOGEN	T3	PA SP
NIVESTYM	T2	SP HD
NYPOZI	T3	PA SP
NYVEPRIA	T2	PA SP
STIMUFEND	T3	PA SP
UDENYCA	T2	PA SP
UDENYCA AUTOINJECTOR	T2	PA SP
UDENYCA ONBODY	T2	PA SP
ZARXIO	T2	SP HD
ZIEXTENZO	T3	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T2	PA SP HD
DOPTELET SPRINKLE	T2	PA SP HD
eltrombopag olamine (Promacta)	T1	PA SP HD
MULPLETA	T3	PA SP HD
LEUKOCYTE (WBC) STIMULANTS		
RELEUKO	T3	PA SP
ROLVEDON	T2	PA SP

COLONY STIMULATING FACTORS (Cancer)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
XOLREMDI	T3	PA QL(4 CAPS/DAY) SP CSL

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List of Prescription Medications

CONTRACEPTIVES (Contraception Products)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
etonogestrel/ethinyl estradiol (Nuvaring)	T1	PPACA
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T2	SP PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA *(medroxyprogesterone acetate)*	T3	PPACA
DEPO-SUBQ PROVERA 104	T3	PPACA
medroxyprogesterone 150 mg/ml (Depo-Provera)	T1	PPACA
CONTRACEPTIVES,ORAL		
desog-e.estradiol/e.estradiol	T1	HD PPACA
desogestrel-ethinyl estradiol	T1	HD PPACA
drospir/eth estra/levomefol ca (Beyaz)	T1	HD PPACA
drospir/eth estra/levomefol ca (Safyral)	T1	HD PPACA
ELLA	T3	HD PPACA
ethinyl estradiol/drospirenone (Yasmin 28)	T1	HD PPACA
ethinyl estradiol/drospirenone (Yaz)	T1	HD PPACA
ethynodiol d-ethinyl estradiol	T1	HD PPACA
levonorgest/eth.estradiol/iron (Balcoltra)	T1	HD PPACA
levonorgestrel/ethin.estradiol	T1	HD PPACA
l-norgest/e.estradiol-e.estrad	T1	HD PPACA
noreth-ethinyl estradiol/iron	T1	HD PPACA
noreth-ethinyl estradiol/iron	T3	HD PPACA
norethind-eth estrad 1-0.02 mg (Loestrin)	T1	HD PPACA
norethindrone	T1	HD PPACA
norethindrone ac/eth estradiol (Loestrin)	T1	HD PPACA
norethindrone-e.estradiol-iron	T1	HD PPACA
norethindrone-e.estradiol-iron (Loestrin Fe)	T1	HD PPACA
norethindrone-e.estradiol-iron (Taytulla)	T1	HD PPACA
norethindrone-ethin. estradiol	T1	HD PPACA
norethin-ee 1.5-0.03 mg(21) tb (Loestrin)	T1	HD PPACA
norgestimate-ethinyl estradiol	T1	HD PPACA
norgestrel-ethinyl estradiol	T1	HD PPACA

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List of Prescription Medications

CONTRACEPTIVES (Contraception Products) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, TRANSDERMAL		
norelgestromin/ethin.estradiol	T1	HD PPACA
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T2	PPACA
FEMCAP	T2	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T3	SP PPACA
LILETTA	T3	SP PPACA
MIRENA	T3	SP PPACA
MIUDELLA	T3	SP PPACA
PARAGARD T 380-A	T3	SP PPACA
PARAGARD T 380A (SINGLE HAND)	T3	SP PPACA
SKYLA	T3	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
IST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R. (*pseudoephed/chlor-mal/bell alk*)	T3	
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTI-TUSSIVES, NON-OPIOID		
benzonatate 100 mg capsule	T1	
benzonatate 200 mg capsule	T1	
NON-OPIOID ANTI-TUS-IST GEN.ANTIHISTAMINE-DECONGEST		
brompheniramine/pseudoephed/dm (Bromfed Dm)	T1	
NON-OPIOID ANTI-TUSSIVE-IST GEN ANTIHISTAMINE COMB.		
promethazine/dextromethorphan	T1	
OPIOID ANTI-TUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST		
CAPCOF	T3	
HISTEX-AC	T3	
MAXI-TUSS CD	T3	
POLY-TUSSIN AC	T3	
promethazine/phenyleph/codeine	T1	PA QL(480 MLS/30 DAYS)

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List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANTI-TUSSIVE-IST GENERATION ANTIHISTAMINE		
hydrocodone/chlorphen p-stirex	T1	PA
promethazine hcl/codeine	T1	PA QL(480 MLS/30 DAYS)
TUXARIN ER	T3	PA QL(2 TABS/DAY)
TUZISTRA XR	T3	PA QL(960 MLS/30 DAYS)
OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS		
HYCODAN 5 MG-1.5 MG TABLET (*hydrocodone bit/homatrop me-br*)	T3	PA QL(180 TABS/30 DAYS)
HYCODAN 5 MG-1.5 MG/5 ML CUP	T3	PA QL(480 MLS/30 DAYS)
HYCODAN 5 MG-1.5 MG/5 ML SOLN (*hydrocodone bit/homatrop me-br*)	T3	PA QL(480 MLS/30 DAYS)
hydrocodone bit/homatrop me-br (Hycodan)	T1	PA QL(480 MLS/30 DAYS)
hydrocodone-homatrop 5 ml cup	T1	PA QL(480 MLS/30 DAYS)
hydrocodone-homatropine 5-1.5 (Hycodan)	T1	PA QL(180 TABS/30 DAYS)
hydrocodone-homatropine soln (Hycodan)	T1	PA QL(480 MLS/30 DAYS)
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB		
CODITUSSIN DAC	T3	
OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION		
codeine phosphate/guaifenesin	T1	
CODITUSSIN AC	T1	
GUAIFENESIN-CODEINE	T1	
MAR-COF CG	T3	
NINJACOF-XG	T1	
OBREDON	T3	PA QL(960 MLS/30 DAYS)
DIAGNOSTIC (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE INSULINX	T2	
FREESTYLE INSULINX TEST STRIPS	T2	
FREESTYLE LITE TEST STRIP	T2	
FREESTYLE PRECISION NEO	T2	
FREESTYLE TEST STRIPS	T2	
PRECISION XTRA TEST STRIPS	T2	
RELION TRUE METRIX TEST STRIP	T2	
TRUE METRIX GLUCOSE TEST STRIP	T2	
URINE GLUCOSE TEST AIDS		
DIASTIX REAGENT	T1	

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DIAGNOSTIC (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BLOOD TESTING PREPARATIONS		
FORA GTEL KETONE TEST STRIP	T1	
FORA TN'G ADV VOICE KETO STRIP	T1	
GOJJI BLOOD KETONE TEST STRIP	T1	
NOVAMAX PLUS	T1	
PRECISION XTR B-KETONE STRIP	T1	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ADVANCED DNA MEDICATED COLLECT	T3	
ARIDOL	T3	
lidocaine hcl/glycerin	T1	
PROVOCHOLINE	T3	
TC 99M SULFUR COLLOID PREP	T1	
EYE DIAGNOSTIC AGENTS		
fluorescein sodium	T1	
ful-glo 1 mg opth strip	T1	
FUL-GLO EYE STRIPS	T3	
lissamine green	T1	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
diatrizoate meglumine, sodium (Gastrografin)	T1	
ENTERO VU	T3	
E-Z DISK	T3	
E-Z-HD	T3	
E-Z-PAQUE	T3	
E-Z-PASTE	T3	
GASTROGRAFIN (*diatrizoate meglumine, sodium*)	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	
NEULUMEX	T3	
POLIBAR ACB	T3	
READI-CAT 2	T3	
SITZMARKS	T3	
TAGITOL V	T3	

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DIAGNOSTIC (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS *(cont.)*		
VANILLA SILQ	T3	
VARIBAR HONEY	T3	
VARIBAR NECTAR	T3	
VARIBAR PUDDING	T3	
VARIBAR THIN HONEY	T3	
VARIBAR THIN LIQUID	T3	
METABOLIC FUNCTION DIAGNOSTICS		
METOPIRONE	T3	
RADIOPHARMACEUTICALS ELEMENTS		
INDICLOR	T3	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	
URINE ACETONE TEST AIDS		
KETONE CARE TEST STRIP	T1	
KETONE TEST STRIP	T1	
KETOSTIX REAGENT	T1	
TRUEPLUS KETONE TEST STRIP	T1	
URINE MULTIPLE TEST AIDS		
CHEK-STIX	T1	
CHEMSTRIP	T1	
CHEMSTRIP 10 WITH SG	T1	
CHEMSTRIP 2 GP	T1	
CHEMSTRIP 50B	T1	
CHEMSTRIP 7	T1	
CHEMSTRIP 9	T1	
COMBISTIX REAGENT	T1	
HEMA-COMBISTIX	T1	
KETO-DIASTIX REAGENT	T1	
LABSTIX REAGENT	T1	
MULTISTIX	T1	
MULTISTIX 10 SG	T1	
MULTISTIX 5	T1	

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DIAGNOSTIC (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
URINE MULTIPLE TEST AIDS *(cont.)*		
MULTISTIX 7	T1	
MULTISTIX 8 SG	T1	
MULTISTIX 9	T1	
MULTISTIX 9 SG	T1	
URISTIX 4	T1	
URISTIX REAGENT	T1	
DIURETICS (Diuretics)		
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
tolvaptan 15 mg tablet (Samsca)	T1	SP
tolvaptan 30 mg tablet (Samsca)	T1	SP
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide	T1	HD
methazolamide	T1	HD
LOOP DIURETICS		
bumetanide	T1	HD
furosemide	T1	HD
furosemide (Lasix)	T1	HD
torsemide	T1	HD
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG		
tolvaptan 15 mg tablet (Jynarque)	T1	SP
tolvaptan 15 mg-15 mg tablet (Jynarque)	T1	PA SP
tolvaptan 30 mg tablet (Jynarque)	T1	SP
tolvaptan 30 mg-15 mg tablet (Jynarque)	T1	PA SP
tolvaptan 45 mg-15 mg tablet (Jynarque)	T1	PA SP
tolvaptan 60 mg-30 mg tablet (Jynarque)	T1	PA SP
tolvaptan 90 mg-30 mg tablet (Jynarque)	T1	PA SP
POTASSIUM SPARING DIURETICS		
amiloride hcl	T1	HD
CAROSPIR (*spironolactone*)	T2	PA
eplerenone (*Inspra*)	T1	HD
KERENDIA	T2	PA QL(1 TAB/DAY)
spironolactone 100 mg tablet (Aldactone)	T1	HD
spironolactone 25 mg tablet (Aldactone)	T1	HD

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List of Prescription Medications

DIURETICS (Diuretics) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
POTASSIUM SPARING DIURETICS *(cont.)*		
spironolactone 25 mg/5 ml susp (Carospir)	T1	
spironolactone 50 mg tablet (Aldactone)	T1	HD
triamterene (Dyrenium)	T1	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
amiloride/hydrochlorothiazide	T1	HD
spironolact/hydrochlorothiazid	T1	HD
triamterene/hydrochlorothiazid	T1	HD
THIAZIDE AND RELATED DIURETICS		
chlorthalidone	T1	HD
DIURIL	T3	HD
hydrochlorothiazide	T1	HD
indapamide	T1	HD
metolazone	T1	HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
azelastine 0.1% (137 mcg) spry	T1	HD
olopatadine 665 mcg nasal spry (Patanase)	T1	HD
PATANASE *(olopatadine hcl)*	T3	HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
azelastine/fluticasone (Dymista)	T1	HD
NASAL ANTI-INFLAMMATORY STEROIDS		
flunisolide	T1	HD
fluticasone prop 50 mcg spray	T1	HD
mometasone furoate 50 mcg spry	T1	QL(68 GMS/30 DAYS) HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
ipratropium bromide	T1	HD
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T3	
epinephrine hcl	T1	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (*fluocinolone acetonide oil*)	T3	
fluocinolone acetonide oil (Dermotic)	T1	

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List of Prescription Medications

EENT PREPS (Ear Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
acetic acid	T1	
hydrocortisone/acetic acid	T1	
EENT PREPS (Eye Conditions)		
ARTIFICIAL TEARS		
LACRISERT	T3	
MIEBO	T2	QL(4 BOTTLES/30 DAYS)
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T3	
EYE ANTI-INFLAMMATORY AGENTS		
bromfenac sodium	T1	
bromfenac sodium (Bromsite)	T1	
bromfenac sodium (Prolensa)	T1	
dexamethasone sodium phosphate	T1	
diclofenac 0.1% eye drops	T1	
difluprednate (Durezol)	T1	
EYSUVIS	T2	QL(8.3 ML/14 DAYS)
fluorometholone (Fml)	T1	
flurbiprofen sodium	T1	
ILEVRO	T3	
ketorolac 0.4% ophth solution (Acular Ls)	T1	
ketorolac 0.5% ophth solution (Acular)	T1	
loteprednol etabonate (Alrex)	T1	
loteprednol etabonate (Lotemax)	T1	
prednisolone acetate (Pred Forte)	T1	
prednisolone sodium phosphate	T1	
PROLENSA *(bromfenac sodium)*	T3	
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (*proparacaine hcl)*	T3	
ALTAFLUOR BENOX (*benoxinate hcl/fluorescein sod*)	T3	
FLUORESCEIN-BENOXINATE	T3	
proparacaine hcl (Alcaine)	T1	

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List of Prescription Medications

EENT PREPS (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE LOCAL ANESTHETICS *(cont.)*		
proparacaine/fluorescein sod	T1	
tetracaine hcl	T1	
TETRACAINE HCL	T1	
EYE MAST CELL STABILIZERS		
cromolyn 4% eye drops	T1	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICTORS		
phenylephrine hcl	T1	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
apraclonidine hcl	T1	HD
betaxolol hcl	T1	HD
BETOPTIC S	T2	HD
bimatoprost	T1	QL(10 MLS/30 DAYS) HD
brimonidine tartrate	T1	HD
brimonidine tartrate (Alphagan P)	T1	HD
brimonidine tartrate/timolol (Combigan)	T1	HD
brinzolamide (Azopt)	T1	HD
carteolol hcl	T1	HD
dorzolamide hcl	T1	HD
dorzolamide hcl/timolol maleat (Cosopt)	T1	HD
dorzolamide/timolol/pf (Cosopt Pf)	T1	HD
latanoprost (Xalatan)	T1	HD
levobunolol hcl	T1	HD
PHOSPHOLINE IODIDE	T3	SP HD
pilocarpine 1% eye drops	T1	HD
pilocarpine 2% eye drops	T1	HD
pilocarpine 4% eye drops	T1	HD
RHOPRESSA	T3	
ROCKLATAN	T3	
SIMBRINZA	T2	HD
tafluprost/pf (Zioptan)	T1	QL(60 DROPPERS/30 DAYS) HD

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List of Prescription Medications

EENT PREPS (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS *(cont.)*		
timolol (Betimol)	T1	HD
timolol maleate (Istalol)	T1	HD
timolol maleate (Timoptic)	T1	HD
timolol maleate (Timoptic-Xe)	T1	HD
timolol maleate/pf	T1	HD
timolol maleate/pf (Timoptic Ocudose)	T1	HD
travoprost (Travatan Z)	T1	HD
MYDRIATICS		
atropine 1% eye drop	T1	HD
atropine 1% eye drops	T1	HD
atropine 1% eye ointment	T1	HD
CYCLOGYL	T3	HD
CYCLOGYL (*cyclopentolate hcl*)	T3	HD
CYCLOMYDRIL	T3	HD
cyclopentolate hcl	T1	HD
cyclopentolate hcl (Cyclogyl)	T1	HD
homatropine hbr	T1	HD
MYDRIACYL (*tropicamide*)	T3	HD
PAREMYD	T3	HD
tropicamide	T1	HD
tropicamide (Mydriacyl)	T1	HD
OPHTHALMIC ANTI-FIBROTIC AGENTS		
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T2	
cyclosporine 0.05% eye emuls (Restasis)	T1	HD
RESTASIS (*cyclosporine*)	T2	HD
XIIDRA	T2	HD
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTADROPS	T3	PA QL(20 MLS/28 DAYS) SP
CYSTARAN 0.44% EYE DROPS	T3	PA QL(120 MLS/28 DAYS) SP

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EENT PREPS (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T3	PA SP HD
OPHTHALMIC TRPM8 AGONISTS		
TRYPTYR	T3	
ELECT/CALORIC/H2O (Cholesterol Medications)		
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T3	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
FLORIVA 0.25 MG/ML DROPS	T3	
fluoride (sodium)	T1	
fluoride (sodium) (Prevident 5000 Plus)	T1	
fluoride (sodium) (Prevident)	T1	
FLUORIDEX	T1	
FLUORIDEX SENSITIVITY RELIEF	T3	
FLUORIMAX 5000	T3	
FLUORIMAX 5000 SENSITIVE	T3	
FRAICHE 5000 PREVI	T3	
JUST RIGHT 5000	T3	
PREVIDENT	T3	
PREVIDENT *(fluoride (sodium))*	T3	
PREVIDENT 5000 DRY MOUTH	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 SENSITIVE	T3	
PREVIDENT KIDS	T3	
sodium fluoride 0.2% rinse (Prevident)	T1	
sodium fluoride 1.1% cream (Prevident 5000 Plus)	T1	
sodium fluoride 1.1% gel (Prevident)	T1	
sodium fluoride 5000 ppm paste	T1	
sodium fluoride/potassium nit	T1	

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List of Prescription Medications

ELECT/CALORIC/H2O (Dental Products) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PEDIATRIC VITAMIN PREPARATIONS		
fluoride (sodium)	T1	PPACA
sodium fluoride 0.25 (0.55) mg	T1	PPACA
sodium fluoride 0.5 mg(1.1 mg)	T1	PPACA
sodium fluoride 0.5 mg/ml drop	T1	PPACA
sodium fluoride 1 mg (2.2 mg)	T1	PPACA
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
BAQSIMI	T2	QL(2 UNITS/30 DAYS)
diazoxide (Proglycem)	T1	
glucagon 1 mg emergency kit	T1	QL(2 VIALS/30 DAYS)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL(2 KITS/30 DAYS)
ZEGALOGUE AUTOINJECTOR	T2	QL(1.2 ML/30 DAYS)
ZEGALOGUE SYRINGE	T2	QL(1.2 ML/30 DAYS)
ELECT/CALORIC/H2O (Miscellaneous)		
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T3	PA SP
ELECT/CALORIC/H2O (Nutritional/Dietary)		
CALCIUM REPLACEMENT		
calcium/mag/d3/b12/fa/b6/boron	T1	
CARBOHYDRATES		
ENFAMIL	T3	
GLUTOL	T3	
ELECTROLYTE DEPLETERS		
AURYXIA	T3	QL (12 TABS/DAY)
calcium acetate	T1	
lanthanum carbonate (Fosrenol)	T1	
LOKELMA	T2	
MAGNEBIND 400	T3	
sevelamer carbonate (Renvela)	T1	
sevelamer hcl	T1	
sodium polystyrene sulfon/sorb	T1	

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ELECTROLYTE DEPLETERS *(cont.)*		
sodium polystyrene sulfonate	T1	
sps 15 gm/60 ml suspension	T1	
sps 30 gm/120 ml enema susp	T3	
VELPHORO	T2	
VELTASSA	T2	
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
fluoride (sodium)	T1	
fluoride (sodium) (Prevident 5000 Plus)	T1	
fluoride (sodium) (Prevident)	T1	
FLUORIDEX	T1	
FLUORIMAX 5000	T3	
JUST RIGHT 5000	T3	
PREVIDENT	T3	
PREVIDENT *(fluoride (sodium))*	T3	
PREVIDENT 5000 DRY MOUTH	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT KIDS	T3	
sodium fluoride 0.2% rinse (Prevident)	T1	
sodium fluoride 1.1% cream (Prevident 5000 Plus)	T1	
sodium fluoride 1.1% gel (Prevident)	T1	
sodium fluoride 5000 ppm paste	T1	
IODINE CONTAINING AGENTS		
potassium iodide	T1	
potassium iodide/iodine	T1	
SSKI	T3	
IRON REPLACEMENT		
ACCRUFER	T3	
ACTIVE FE	T3	
CITRANATAL BLOOM	T3	
CORVITE 150	T3	
CORVITE FE	T3	
FERIVA 21-7	T3	

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRON REPLACEMENT *(cont.)*		
FERRALET 90	T3	
ferrous fum/vit c/b12-if/folic	T1	
ferrous fumarate/folic acid (Hemocyte-F)	T1	
FUSION PLUS	T3	
HEMATRON-AF	T3	
HEMAX	T3	
HEMOCYTE PLUS *(mv-mins no.73/iron fum/folic)*	T3	
HEMOCYTE-F *(ferrous fumarate/folic acid)*	T3	
INTEGRA F *(iron fum,ps/folic acid/vitc/b3)*	T3	
INTEGRA PLUS *(iron fum,ps/folic/bcomp,c no.9)*	T3	
iron aspgly,ps/c/b12/fa/ca/suc	T1	
iron aspgly/c/b12/fa/ca-th/suc	T1	
iron bg,ps/vitc/b12/fa/calcium	T1	
iron fum,ag/c/b12/folic/ca/suc	T1	
iron fum,ps/folic acid/vitc/b3 (Integra F)	T1	
iron fum,ps/folic/bcomp,c no.9 (Integra Plus)	T1	
iron fumarate/vit c/vit b12/fa	T1	
iron ps complex/b12/folic acid	T1	
iron/c/folic acd/mv cmb11/calc	T1	
iron/folic ac/vit bcomp,c/min	T1	
iron/folic acid/b12/c/docusate	T1	
iron/folic acid/c/b6/b12/zinc	T1	
IROSPAN	T3	
NEONATAL FE	T3	
NUFERA	T3	
PROFERRIN-FORTE	T3	
VITAFOL	T3	
PEDIATRIC VITAMIN PREPARATIONS		
fluoride (sodium)	T1	PPACA
sodium fluoride 0.25 (0.55) mg	T1	PPACA
sodium fluoride 0.5 mg(1.1 mg)	T1	PPACA
sodium fluoride 0.5 mg/ml drop	T1	PPACA
sodium fluoride 1 mg (2.2 mg)	T1	PPACA

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ELECT/CALORIC/H2O (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
POTASSIUM REPLACEMENT *(cont.)*		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
effer-k 25 meq tablet eff	T1	
potassium bicarbonate/cit ac	T1	
potassium chloride	T1	
potassium cl 10% (20 meq/15ml)	T1	
potassium cl 20 meq packet	T1	
potassium cl 20% (40 meq/15ml)	T1	
potassium cl er 10 meq capsule	T1	
potassium cl er 10 meq tablet	T1	
potassium cl er 15 meq tablet	T1	
POTASSIUM CL ER 15 MEQ TABLET	T3	
potassium cl er 20 meq tablet	T1	
potassium cl er 8 meq capsule	T1	
potassium cl er 8 meq tablet	T1	
potassium cl10%(20meq/15ml)cup	T1	
potassium cl10%(40meq/30ml)cup	T1	
potassium cl20%(40meq/15ml)cup	T1	
PROTEIN REPLACEMENT		
AQNEURSA	T3	PA SP
levocarnitine	T1	
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
DIALYSIS SOLUTIONS		
PRISMASOL	T3	
URINARY PH MODIFIERS		
citric acid/sodium citrate	T1	HD
K-PHOS NO.2	T3	HD
K-PHOS ORIGINAL	T3	HD
ORACIT	T3	HD
potassium citrate	T1	HD
potassium citrate (Urocit-K)	T1	HD

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECT/CALORIC/H2O (Urinary Tract Conditions) *(cont.)*		
URINARY PH MODIFIERS *(cont.)*		
potassium citrate/citric acid	T1	HD
RENACIDIN	T3	HD
sod/pot/k cit/sod cit/cit acid	T1	HD
UROCIT-K (*potassium citrate*)	T3	HD
UROQID-ACID NO.2	T3	HD
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
icosapent ethyl (Vascepa)	T1	HD
omega-3 acid ethyl esters (Lovaza)	T1	HD
VASCEPA (*icosapent ethyl*)	T2	PA HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
glycerol phenylbutyrate	T1	SP HD
lactulose	T1	HD
lactulose 10 gm/15 ml solution	T1	
LITHOSTAT	T3	HD
OLPRUVA	T3	PA SP HD
PHEBURANE	T2	PA QL(8 BOTTLES/30 DAYS) SP HD
sodium phenylbutyrate (Buphenyl)	T1	SP HD
ANTI-CHOLINERGICS, QUATERNARY AMMONIUM		
chlordiazepoxide/clidinium br (Librax)	T1	
CUVPOSA (*glycopyrrolate*)	T3	
GLYCATE	T3	
glycopyrrolate 1 mg tablet (Robinul)	T1	
glycopyrrolate 1 mg/5 ml soln (Cuvposa)	T1	
glycopyrrolate 2 mg tablet (Robinul Forte)	T1	
ANTI-CHOLINERGICS/ANTI-SPASMODICS		
dicyclomine 10 mg capsule	T1	
dicyclomine 10 mg/5 ml soln	T1	
dicyclomine 20 mg tablet	T1	
ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS		
MYTESI	T3	SP

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T3	PA SP
ANTIDIARRHEAL MICROORGANISMS AGENTS		
RESTORA RX	T3	
ANTI-DIARRHEALS		
diphenoxylate hcl/atropine	T1	
diphenoxylate hcl/atropine (Lomotil)	T1	
loperamide hcl	T1	
MOTOFEN	T3	
opium tincture	T1	PA
ANTI-EMETIC, CANNABINOID-TYPE		
dronabinol (Marinol)	T1	
ANTI-EMETIC/ANTI-VERTIGO AGENTS		
AKYNZEO	T3	PA QL(4 CAPS/28 DAYS)
aprepitant 125 mg capsule	T1	QL(4 CAPS/28 DAYS)
aprepitant 125-80-80 mg pack (Emend)	T1	QL(12 CAPS/28 DAYS)
aprepitant 40 mg capsule	T1	QL(1 CAP/28 DAYS)
aprepitant 80 mg capsule (Emend)	T1	QL(8 CAPS/28 DAYS)
BONJESTA	T3	
COMPAZINE (*prochlorperazine maleate*)	T3	
COMPAZINE (*prochlorperazine*)	T3	
doxylamine succinate/vit b6 (Diclegis)	T1	QL(4 TABS/DAY)
EMEND 125 MG POWDER PACKET	T3	PA QL(12 PACKS/28 DAYS)
EMEND 150 MG VIAL (*fosaprepitant dimeglumine*)	T3	
fosaprepitant dimeglumine (Emend)	T1	
granisetron hcl	T1	
granisetron hcl/pf	T1	
ondansetron hcl	T1	
ondansetron hcl/pf	T1	
ondansetron odt 4 mg tablet	T1	
ondansetron odt 8 mg tablet	T1	
prochlorperazine (Compazine)	T1	
prochlorperazine maleate (Compazine)	T1	
promethazine hcl	T1	
SANCUSO	T3	PA QL(4 PATCHES/30 DAYS)

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-EMETIC/ANTI-VERTIGO AGENTS *(cont.)*		
scopolamine (Transderm-Scop)	T1	
TRANSDERM-SCOP *(scopolamine)*	T3	
trimethobenzamide hcl	T1	
VARUBI	T3	PA QL(4 TABS/28 DAYS)
ANTI-ULCER PREPARATIONS		
CYTOTEC (*misoprostol*)	T3	HD
misoprostol (Cytotec)	T1	HD
sucralfate	T1	HD
sucralfate (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
bismuth/metronid/tetracycline (Pylera)	T1	
lansoprazole/amoxiciln/clarith	T1	
BELLADONNA ALKALOIDS		
hyoscyamine sulfate	T1	HD
hyoscyamine sulfate (Levbid)	T1	HD
hyoscyamine sulfate (Levsin)	T1	HD
hyoscyamine sulfate (Levsin-SL)	T1	HD
hyoscyamine sulfate (Nulev)	T1	HD
hyoscyamine sulfate (Nulev)	T3	HD
LEVSIN (*hyoscyamine sulfate*)	T3	HD
methscopolamine bromide	T1	HD
NULEV *(hyoscyamine sulfate)*	T3	HD
phenobarb/hyoscy/atropine/scop	T1	HD
phenobarb/hyoscy/atropine/scop (Donnatal)	T1	HD
phenobarb/hyoscy/atropine/scop (Phenobarbital-Belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA *(phenobarb/hyoscy/atropine/scop)*	T3	HD
SYMAX DUOTAB	T3	HD
BILE SALTS		
CHENODAL	T3	PA SP HD
CHOLBAM	T3	PA SP HD
CTEXLI	T3	PA SP
URSO FORTE (*ursodiol*)	T3	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BILE SALTS *(cont.)*		
ursodiol 250 mg tablet	T1	HD
ursodiol 300 mg capsule	T1	HD
ursodiol 500 mg tablet (Urso Forte)	T1	HD
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
mesalamine 1,000 mg supp (Canasa)	T1	
mesalamine 4 gm/60 ml enema (Sfrowasa)	T1	
mesalamine 4 gm/60 ml kit (Rowasa)	T1	
SFROWASA (*mesalamine*)	T3	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (*mesalamine*)	T3	HD
balsalazide disodium (Colazal)	T1	HD
mesalamine	T1	HD
mesalamine (Apriso)	T1	HD
mesalamine (Pentasa)	T1	HD
mesalamine 800 mg dr tablet (Asacol Hd)	T1	HD
mesalamine dr 1.2 gm tablet (Lialda)	T1	HD
PENTASA 500 MG CAPSULE (*mesalamine*)	T3	HD
sulfasalazine (Azulfidine)	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T3	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST	T3	PA QL(12 CAPS/56 DAYS) SP
GASTRIC ENZYMES		
SUCRAID	T3	PA SP
HEMORRHOID PREP,ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANALPRAM HC 1% CREAM	T3	
hydrocortisone/pramoxine	T1	
hydrocortisone/pramoxine (Analpram Hc)	T1	
PROCORT	T3	
PROCTOFOAM-HC	T3	
HISTAMINE H2-RECEPTOR INHIBITORS		
cimetidine hcl	T1	HD
famotidine	T1	HD

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IBS AGENTS, MIXED OPIOID RECEP AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	
TRULANCE	T2	
INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
ENTYVIO	T2	PA SP HD
INTESTINAL MOTILITY STIMULANTS		
metoclopramide hcl	T1	
metoclopramide hcl (Reglan)	T1	
prucalopride succinate (Motegrity)	T1	
REGLAN (*metoclopramide hcl*)	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
alosetron hcl (Lotronex)	T1	SP HD
LAXATIVES AND CATHARTICS		
bisac/nacl/nahco3/kcl/peg 3350	T1	PPACA
lactulose	T1	
lactulose 10 gm/15 ml soln cup	T1	
lactulose 10 gm/15 ml solution	T1	
lactulose 20 gm packet	T1	
lactulose 20 gm/30 ml soln cup	T1	
lactulose 20 gm/30 ml solution	T1	
lubiprostone (Amitiza)	T1	
peg3350/sod sul/nacl/kcl/asb/c (Moviprep)	T1	PPACA
peg3350/sod sulf,bicarb,cl/kcl	T1	PPACA
peg3350/sod sulf,bicarb,cl/kcl (Golytely)	T1	PPACA
sodium chloride/nahco3/kcl/peg	T1	PPACA
sodium, potassium,mag sulfates (Suprep)	T1	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
nitroglycerin 0.4% ointment (Rectiv)	T1	
RECTIV (*nitroglycerin*)	T3	
PANCREATIC ENZYMES		
PANCREAZE	T2	HD
VIOKACE	T3	HD
ZENPEP	T2	HD

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T3	PA QL(1 TAB/DAY)
PROTON-PUMP INHIBITORS		
dexlansoprazole dr 30 mg cap	T1	QL(2 CAPS/DAY)
dexlansoprazole dr 60 mg cap	T1	QL(1 CAP/DAY)
*esomeprazole dr 10 mg packet (*Nexium*)*	T1	QL(4 PACKS/DAY) HD
*esomeprazole dr 2.5 mg packet (*Nexium*)*	T1	QL(16 PACKS/DAY) HD
*esomeprazole dr 20 mg packet (*Nexium*)*	T1	QL(2 PACKS/DAY) HD
*esomeprazole dr 40 mg packet (*Nexium*)*	T1	QL(1 PACK/DAY) HD
*esomeprazole dr 5 mg packet (*Nexium*)*	T1	QL(8 PACKS/DAY) HD
esomeprazole mag dr 20 mg cap	T1	QL(2 CAPS/DAY) HD
esomeprazole mag dr 40 mg cap	T1	QL(1 CAP/DAY) HD
esomeprazole sodium	T1	
lansoprazole dr 15 mg capsule	T1	QL(2 CAPS/DAY) HD
*lansoprazole dr 15 mg odt (*Prevacid*)*	T1	QL(2 TABS/DAY) HD
lansoprazole dr 30 mg capsule	T1	QL(1 CAP/DAY) HD
*lansoprazole dr 30 mg odt (*Prevacid*)*	T1	QL(1 TAB/DAY) HD
omeprazole dr 10 mg capsule	T1	QL(4 CAPS/DAY) HD
omeprazole dr 20 mg capsule	T1	QL(2 CAPS/DAY) HD
omeprazole dr 40 mg capsule	T1	QL(1 CAP/DAY) HD
omeprazole-bicarb 20-1,100 cap	T1	PA QL(2 CAPS/DAY) HD
omeprazole-bicarb 20-1,680 pkt	T1	PA QL(2 PACKS/DAY) HD
omeprazole-bicarb 40-1,100 cap	T1	PA QL(1 CAP/DAY) HD
omeprazole-bicarb 40-1,680 pkt	T1	PA QL(1 PACK/DAY) HD
pantoprazole dr 40 mg susp pkt	T1	QL(1 PACK/DAY) HD
pantoprazole sod dr 20 mg tab	T1	QL(2 TABS/DAY) HD
pantoprazole sod dr 40 mg tab	T1	QL(1 TAB/DAY) HD
pantoprazole sodium 40 mg vial	T1	
rabeprazole sodium	T1	QL(1 TAB/DAY) HD
RECTAL PREPARATIONS		
hydrocortisone acetate	T1	
hydrocortisone acetate (Anusol-Hc)	T1	
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T3	PA SP HD

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List of Prescription Medications

GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T1	
ANALPRAM HC 1% CREAM	T3	
hydrocortisone/lidocaine/aloe	T1	
hydrocortisone/pramoxine	T1	
hydrocortisone/pramoxine (Analpram Hc)	T1	
lidocaine/hydrocortisone ac	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T3	
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
budesonide 2 mg rectal foam (Uceris)	T1	QL(2 KITS/180 DAYS)
CORTENEMA (*hydrocortisone*)	T3	
hydrocortisone (Cortenema)	T1	
HORMONES (Hormonal Agents)		
ADRENAL STEROID INHIBITORS		
ISTURISA	T3	PA QL (2 TABS/DAY) SP
ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC		
INTRAROSA	T3	QL(30 INSERTS/30 DAYS)
ANDROGENIC AGENTS		
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE (testosterone cypionate)	T3	
METHITEST	T1	
methyltestosterone	T1	
oxandrolone	T1	PA
testosterone 1% (25mg/2.5g) pk (Androgel)	T1	PA QL(150 GMS/30 DAYS)
testosterone 1% (50 mg/5 g) pk (Androgel)	T1	PA QL(300 GMS/30 DAYS)
testosterone 1.62% (2.5 g) pkt	T1	PA QL(150 GMS/30 DAYS)
testosterone 1.62% gel pump (Androgel)	T1	PA QL(150 GMS/30 DAYS)
testosterone 1.62%(1.25 g) pkt	T1	PA QL(75 GMS/30 DAYS)
testosterone 10 mg gel pump	T1	PA QL(120 GMS/30 DAYS)
testosterone 12.5 mg/1.25 gram	T1	PA QL(150 GMS/30 DAYS)

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List of Prescription Medications

HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANDROGENIC AGENTS *(cont.)*		
testosterone 30 mg/1.5 ml pump	T1	PA QL(180 MLS/30 DAYS)
testosterone 50 mg/5 gram gel (Testim)	T1	PA QL(10 GMS/DAY)
testosterone 50 mg/5 gram gel (Vogelxo)	T1	PA QL(10 GMS/DAY)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL(300 GMS/30 DAYS)
testosterone cypionate	T1	
testosterone cypionate (Depo-Testosterone)	T1	
testosterone enanthate	T1	
XYOSTED	T3	PA QL(2 ML/28 DAYS)
ANTI-DIURETIC AND VASOPRESSOR HORMONES		
desmopressin (nonrefrigerated)	T1	
desmopressin 0.01% solution	T1	HD
desmopressin 10 mcg/0.1 ml spr	T1	HD
desmopressin 40 mcg/10 ml vial (Ddavp)	T1	SP
desmopressin ac 4 mcg/ml ampul (Ddavp)	T1	SP
desmopressin ac 4 mcg/ml vial (Ddavp)	T1	SP
desmopressin acetate	T1	
desmopressin acetate 0.1 mg tb (Ddavp)	T1	HD
desmopressin acetate 0.2 mg tb (Ddavp)	T1	HD
NOCTIVA	T3	PA
STIMATE	T3	SP
ANTIDIURETIC AND VASOPRESSOR HORMONES		
desmopressin 0.01% solution	T1	HD
desmopressin 10 mcg/0.1 ml spr	T1	HD
desmopressin 40 mcg/10 ml vial (Ddavp)	T1	SP
desmopressin ac 4 mcg/ml ampul (Ddavp)	T1	SP
desmopressin ac 4 mcg/ml vial (Ddavp)	T1	SP
desmopressin acetate 0.1 mg tb (Ddavp)	T1	HD
desmopressin acetate 0.2 mg tb (Ddavp)	T1	HD
NOCTIVA	T3	PA
ESTROGEN AND PROGESTIN COMBINATIONS		
BIJUVA	T3	
ESTROGEN/ANDROGEN COMBINATIONS		
estrogen, ester/me-testosterone	T1	HD
estrogen, ester/me-testosterone (Estratest F.S.)	T1	HD

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List of Prescription Medications

HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ESTROGENIC AGENTS		
COMBIPATCH	T2	
DEPO-ESTRADIOL	T3	HD
estradiol (Climara)	T1	HD
estradiol (Minivelle)	T1	QL(16 PATCHES/28 DAYS) HD
estradiol (Vivelle-Dot)	T1	QL(16 PATCHES/28 DAYS) HD
estradiol 0.06% 1.25g gel pump (Estrogel)	T1	HD
estradiol 0.1% (0.25mg) gel pk (Divigel)	T1	HD
estradiol 0.1% (0.5mg) gel pkt (Divigel)	T1	HD
estradiol 0.1% (0.75mg) gel pk (Divigel)	T1	HD
estradiol 0.1% (1 mg) gel pkt (Divigel)	T1	HD
estradiol 0.1% (1.25mg) gel pk (Divigel)	T1	HD
estradiol 0.5 mg tablet	T1	HD
estradiol 1 mg tablet	T1	HD
estradiol 2 mg tablet	T1	HD
estradiol valerate (Delestrogen)	T1	HD
estradiol/norethindrone acet	T1	HD
estradiol/norethindrone acet (Activella)	T1	HD
estrogens, conjugated (Premarin)	T1	HD
EVAMIST	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL(8 PATCHES/28 DAYS) HD
norethind-eth estrad 0.5-2.5	T1	HD
norethindrone ac/eth estradiol	T1	HD
norethin-eth estrad 1 mg-5 mcg	T1	HD
PREMARIN *(estrogens, conjugated)*	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
budesonide	T1	
budesonide (Uceris)	T1	PA QL(1 TAB/DAY)

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HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GLUCOCORTICOIDS *(cont.)*		
cortisone acetate	T1	
deflazacort (Emflaza)	T1	PA SP
deflazacort (Emflaza)	T1	PA SP HD
dexamethasone	T1	
dexamethasone 0.5 mg tablet	T1	
dexamethasone 0.5 mg/5 ml elx	T1	
dexamethasone 0.5 mg/5 ml liq	T1	
dexamethasone 0.75 mg tablet	T1	
dexamethasone 1 mg tablet	T1	
dexamethasone 1.5 mg tablet	T1	
dexamethasone 2 mg tablet	T1	
dexamethasone 4 mg tablet	T1	
dexamethasone 6 mg tablet	T1	
hydrocortisone (Cortef)	T1	
MEDROL	T3	
MEDROL *(methylprednisolone)*	T3	
methylprednisolone	T1	
methylprednisolone (Medrol)	T1	
ORAPRED ODT *(prednisolone sodium phosphate)*	T3	
prednisolone	T1	
prednisolone sodium phosphate	T1	
prednisolone sodium phosphate (Orapred Odt)	T1	
prednisone	T1	
UCERIS 9 MG ER TABLET (*budesonide*)	T3	PA QL(1 TAB/DAY)
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA SV	T3	PA SP HD
EGRIFTA WR	T3	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T2	PA SP HD
OMNITROPE	T2	PA SP HD
SEROSTIM	T2	PA SP HD
SKYTROFA	T2	PA SP HD
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T2	PA SP HD

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List of Prescription Medications

HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT 11.25 MG 3MO KIT	T2	PA SP HD
LUPRON DEPOT 3.75 MG KIT	T2	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T2	PA QL(1 TAB/DAY)
ORIAHNN	T2	PA QL(2 CAPS/DAY)
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
cetrorelix acetate (Cetrotide)	T1	PA SP
CETROTIDE (*cetrorelix acetate*)	T2	PA SP
ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)	T1	PA SP
GANIRELIX ACET 250 MCG/0.5 ML (*ganirelix acetate*)	T2	PA SP
ganirelix acetate (Ganirelix Acetate)	T1	PA SP
ORILISSA 150 MG TABLET	T2	PA QL(1 TAB/DAY)
ORILISSA 200 MG TABLET	T2	PA QL(2 TABS/DAY)
LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY		
FENSOLVI	T2	PA SP
LUPRON DEPOT-PED	T3	PA SP HD
MINERALOCORTICOIDS		
fludrocortisone acetate	T1	HD
OXYTOCICS		
CERVIDIL	T3	
methylergonovine maleate	T1	
PREPIDIL	T3	
PARATHYROID HORMONES		
YORVIPATH	T3	PA SP
PITUITARY SUPPRESSIVE AGENTS		
cabergoline	T1	QL(16 TABS/28 DAYS) HD
CRENESSITY 25 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP
CRENESSITY 50 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP
CRENESSITY 100 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP
CRENESSITY 50 MG/ML SOLUTION	T3	PA QL(8 MLS/DAY) SP
danazol	T1	HD
PROGESTATIONAL AGENTS		
CRINONE 4% GEL	T3	PA HD
medroxyprogesterone 10 mg tab (Provera)	T1	HD

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List of Prescription Medications

HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PROGESTATIONAL AGENTS *(cont.)*		
medroxyprogesterone 2.5 mg tab (Provera)	T1	HD
medroxyprogesterone 5 mg tab (Provera)	T1	HD
norethindrone acetate	T1	HD
progesterone 100 mg capsule (Prometrium)	T1	HD
progesterone 200 mg capsule (Prometrium)	T1	HD
SOMATOSTATIC AGENTS		
lanreotide 120 mg/0.5 ml syrng	T1	PA SP HD
LANREOTIDE 120 MG/0.5 ML SYRNG	T3	PA SP HD
octreotide acetate	T1	PA SP HD
octreotide acetate (Sandostatin)	T1	PA SP HD
octreotide acetate,mi-spheres (Sandostatin Lar Depot)	T1	PA SP
SANDOSTATIN (*octreotide acetate*)	T3	PA SP HD
SANDOSTATIN LAR DEPOT *(octreotide acetate,mi-spheres)*	T3	PA SP
SIGNIFOR	T3	PA SP
SIGNIFOR LAR	T3	PA SP
SOMATULINE DEPOT	T2	PA SP HD
VAGINAL ESTROGEN PREPARATIONS		
estradiol (Vagifem)	T1	QL(36 TABS/28 DAYS)
estradiol 0.01% cream (Estrace)	T1	HD
estradiol 10 mcg vaginal insrt (Vagifem)	T1	QL(36 TABS/28 DAYS) HD
PREMARIN	T2	HD
HORMONES (Infertility)		
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
clomiphene citrate	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T2	PA SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T3	PA SP
GONAL-F	T2	PA SP
GONAL-F RFF REDI-JECT	T2	PA SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONADOTROPIN	T3	PA SP
NOVAREL	T2	PA SP

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List of Prescription Medications

HORMONES (Infertility) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HUMAN CHORIONIC GONADOTROPIN (HCG) *(cont.)*		
OVIDREL	T2	PA SP
PREGNYL	T2	PA SP
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T2	
ENDOMETRIN *(progesterone, micronized)*	T2	
progesterone 100 mg vag insert (Endometrin)	T1	
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T3	PA SP HD
HORMONES (Osteoporosis Products)		
BONE RESORPTION INHIBITORS		
calcitonin,salmon,synthetic	T1	HD
*calcitonin,salmon,synthetic (*Miacalcin*)*	T1	HD
MIACALCIN *(calcitonin,salmon,synthetic)*	T3	HD
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB		
SELARSDI	T2	PA QL(1 SYRINGE/84 DAYS) SP
STELARA	T2	PA QL(1 SYRINGE/84 DAYS) SP HD
USTEKINUMAB-TTWE	T2	PA QL(1 SYRINGE/84 DAYS) SP HD
YESINTEK	T2	PA QL(1 SYRINGE/84 DAYS) SP
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH 100 MG/ML PEN	T2	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 100 MG/ML SYRINGE	T2	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 PENS	T2	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 SYRINGES	T2	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG/2 ML PEN	T2	PA QL SP HD
OMVOH 200 MG/2 ML SYRINGE	T2	PA QL SP HD
OMVOH 300 MG DOSE - 2 PENS	T2	PA QL(3 MLS/28 DAYS) SP HD
OMVOH 300 MG DOSE - 2 SYRINGES	T2	PA QL(3 MLS/28 DAYS) SP HD
SKYRIZI ON-BODY	T2	PA QL(1 CARTRIDGE/56 DAYS) SP HD
TREMFYA	T2	PA QL(1 SYRINGE/56 DAYS) SP HD
TREMFYA 100 MG/ML PEN	T2	PA QL(1 ML/56 DAYS) SP HD

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY *(cont.)*		
TREMFYA 200 MG/2 ML PEN	T2	PA QL(2 SYRINGE/28 DAYS) SP HD
TREMFYA ONE-PRESS	T2	PA QL(1 AUTO-INJ/56 DAYS) SP HD
TREMFYA PEN INDUCTION (2 PEN)	T2	PA QL(12 MLS/365 DAYS) SP HD
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT PEN	T2	PA SP HD
DUPIXENT SYRINGE	T2	PA SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA	T2	PA QL(3.6 ML/28 DAYS) SP HD
ACTEMRA ACTPEN	T2	PA QL(3.6 ML/28 DAYS) SP HD
ENSPRYNG	T3	PA SP HD
KEVZARA	T3	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
TYENNE	T2	PA QL(3.6 ML/28 DAYS) SP
TYENNE AUTOINJECTOR	T2	PA QL(3.6 ML/28 DAYS) SP
INTERLEUKIN-31(IL-31)RECEPTOR ALPHA ANTAGONIST,MAB		
NEMLUVIO	T2	PA SP HD
IMMUNOSUPPRESSANTS (Skin Conditions)		
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
HYFTOR	T3	PA SP
pimecrolimus (Elidel)	T1	
tacrolimus 0.03% ointment	T1	
tacrolimus 0.1% ointment	T1	
IMMUNOSUPPRESSANTS (Transplant Medications)		
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T3	SP HD
azathioprine 50 mg tablet (Imuran)	T1	SP HD
cyclosporine 100 mg capsule (Sandimmune)	T1	SP HD
cyclosporine 25 mg capsule (Sandimmune)	T1	SP HD
cyclosporine, modified	T1	SP HD
cyclosporine, modified (Neoral)	T1	SP HD
ENVARSUS XR	T3	SP HD
everolimus 0.25 mg tablet (Zortress)	T1	SP HD
everolimus 0.5 mg tablet (Zortress)	T1	SP HD

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IMMUNOSUPPRESSANTS (Transplant Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IMMUNOSUPPRESSIVES *(cont.)*		
everolimus 0.75 mg tablet (Zortress)	T1	SP HD
everolimus 1 mg tablet (Zortress)	T1	SP HD
LUPKYNIS	T3	PA QL(6 CAPS/DAY) SP
mycophenolate mofetil (Cellcept)	T1	SP HD
mycophenolate sodium (Myfortic)	T1	SP HD
PROGRAF 0.2 MG GRANULE PACKET	T3	SP HD
PROGRAF 1 MG GRANULE PACKET	T3	SP HD
SANDIMMUNE 100 MG/ML SOLN	T2	SP HD
sirolimus	T1	SP HD
sirolimus (Rapamune)	T1	SP HD
tacrolimus 0.5 mg capsule (ir) (Prograf)	T1	SP HD
tacrolimus 1 mg capsule (ir) (Prograf)	T1	SP HD
tacrolimus 5 mg capsule (ir) (Prograf)	T1	SP HD
ZORTRESS *(everolimus)*	T3	SP HD
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)		
DIABETIC SUPPLIES		
2TEK	T1	
ACCU-CHEK	T1	
ACCU-CHEK FASTCLIX LANCING DEV	T1	
ACCU-CHEK GUIDE CONTROL SOLN	T1	
ACCU-CHEK SMARTVIEW CONTRL SOL	T1	
ACCU-CHEK SOFTCLIX	T1	
ACCUTREND GLUCOSE CONTROL	T1	
ADJUSTABLE LANCING DEVICE	T1	
ADVANCED LANCING DEVICE	T1	
ADVOCATE CONTROL SOLUTION	T1	
ADVOCATE LANCING DEVICE	T1	
ADVOCATE RAPID-SAFE LANCING DV	T1	
ADVOCATE REDI-CODE+ CTRL SOLN	T1	
AGAMATRIX CONTROL	T1	
AGAMATRIX CONTROL SOLUTION	T1	
ALKALINE BATTERIES	T1	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
ALTERNATE SITE LANCING DEVICE	T1	
AQUA LANCE LANCING DEVICE	T1	
ASSURE 4 CONTROL SOLUTION	T1	
ASSURE CONTROL SOLUTION	T1	
ASSURE DOSE	T1	
ASSURE PRISM	T1	
AT HOME A1C	T1	
AUTOJECT 2	T1	
AUTO-LANCET MINI	T1	
AUTOLET IMPRESSION	T1	
AUTOLET LANCING DEVICE	T1	
AUTOLET LITE	T1	
AUTOLET PLUS	T1	
AUTOPEN	T1	
BLOOD GLUCOSE CONTROL	T1	
BLOOD-GLUCOSE CONTROL	T1	
BREEZE 2	T1	
CAREONE	T1	
CARESENS	T1	
CARESENS S CONTROL SOLUTION	T1	
CARETOUCH CONTROL SOLUTION	T1	
CARETOUCH LANCING DEVICE	T1	
CEQUR SIMPLICITY	T2	
CEQUR SIMPLICITY INSERTER	T2	
CHEMSTRIP BG DIARY	T1	
CHOSEN LANCING DEVICE	T1	
CLEVER CHOICE CONTROL SOLUTION	T1	
CONTOUR	T1	
CONTOUR NEXT CONTROL SOLUTION	T1	
CONTROL SOLUTION	T1	
COOL CONTROL SOLUTION	T1	
DEXCOM G6 RECEIVER	T2	PA QL(1 UNIT/365 DAYS)

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
DEXCOM G6 SENSOR	T2	PA QL(3 SENSORS/30 DAYS)
DEXCOM G6 TRANSMITTER	T2	PA QL(1 UNIT/90 DAYS)
DEXCOM G7 15 DAY SENSOR	T2	PA QL(3 SENSORS/30 DAYS)
DEXCOM G7 RECEIVER	T2	PA QL(1 UNIT/365 DAYS)
DEXCOM G7 SENSOR	T2	PA QL(3 SENSORS/30 DAYS)
DIATRUE	T1	
DROPLET GENTEEL LANCING DEVICE	T1	
DROPLET LANCING DEVICE	T1	
EASY MINI EJECT LANCING DEVICE	T1	
EASY PLUS II CONTROL SOLN HIGH	T1	
EASY PLUS II CONTROL SOLN LOW	T1	
EASY STEP CONTROL SOLUTION	T1	
EASY TALK CONTROL SOLN LOW	T1	
EASY TALK HIGH CONTROL SOLN	T1	
EASY TALK PLUS II HIGH CONTROL	T1	
EASY TALK PLUS II LOW CTRL SLN	T1	
EASY TOUCH BLULINK CTRL SOLN	T1	
EASY TOUCH CONTROL SOLUTION	T1	
EASY TOUCH LANCING DEVICE	T1	
EASY TRAK CONTROL SOLN HIGH	T1	
EASY TRAK CONTROL SOLN LOW	T1	
EASY TRAK II CONTROL SOLUTION	T1	
EASYGLUCO PLUS CONTROL NORMAL	T1	
EASYMAX 15 LEVEL 2 SOLUTION	T1	
EASYMAX NORMAL CONTROL SOLN	T1	
ELEMENT COMPACT CONTROL SOLN	T1	
ELEMENT CONTROL SOLUTION	T1	
EMBRACE EVO LEVEL 1 CTRL SOLN	T1	
EMBRACE GLUC CONTROL SOLN HIGH	T1	
EMBRACE GLUCOSE CONTROL SOLN	T1	
EMBRACE LANCING DEVICE	T1	
EMBRACE PRO	T1	
EMBRACE TALK CONTROL SOLUTION	T1	
ENLITE SERTER	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES *(cont.)*		
EVENCARE G2 CONTROL SOLUTION	T1	
EVENCARE G3 CONTROL SOLUTION	T1	
EVOLUTION CONTROL SOLUTION	T1	
FONDCIRCLE CONTROL SOLUTION	T1	
FONDCIRCLE LANCING DEVICE	T1	
FORA 6 CONNECT MULTIFUNCTN MTR	T3	
FORA CONTROL SOLUTION	T1	
FORA GTEL MULTIFUNCTN MONITOR	T1	
FORA KETONE CONTROL SOLUTION	T3	
FORA LANCING DEVICE	T1	
FORA TN'G ADVANCE PRO MONITOR	T3	
FORA TN'GO ADV MOBILE MULT MTR	T3	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
FORACARE GDH	T1	
FORTISCARE	T1	
FREESTYLE CONTROL SOLUTION	T1	
FREESTYLE LIBRE 14 DAY READER	T2	
FREESTYLE LIBRE 14 DAY SENSOR	T2	
FREESTYLE LIBRE 2 PLUS SENSOR	T2	
FREESTYLE LIBRE 2 READER	T2	
FREESTYLE LIBRE 2 SENSOR	T2	
FREESTYLE LIBRE 3 PLUS SENSOR	T2	
FREESTYLE LIBRE 3 READER	T2	
FREESTYLE LIBRE 3 SENSOR	T2	
GE100 CONTROL SOLUTION NORMAL	T1	
GENTEEL VACUUM LANCING DEVICE	T1	
GLUCOCARD 01 CONTROL	T1	
GLUCOCARD EXPRESSION CNTRL SLN	T1	
GLUCOCARD SHINE CONTROL SOLN	T1	
GLUCOCOM AUTOLINK	T1	
GLUCOCOM CONTROL SOLUTION	T1	
GLUCOSE CONTROL	T1	
GLUCOSE CONTROL SOLUTION	T1	
GOJJI GLUCOSE CONTROL SOLUTION	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
GOJJI KETONE CONTROL SOLUTION	T3	
GOJJI LANCING DEVICE	T1	
GOJJI MULTI-FUNCTIONAL METER	T3	
GUARDIAN RT CHARGER	T1	
GUARDIAN TEST PLUG	T1	
GUARDIAN TRANSMITTER TAPE	T1	
HEALTHPRO GLUCOSE CONTROL SOLN	T1	
HEALTHY ACCENTS AUTOLET	T1	
HYPOLANCE	T1	
IHEALTH CONTROL SOLN LEVEL 2	T1	
INCONTROL LANCING DEVICE	T1	
INFINITY CONTROL SOLUTION	T1	
INFINITY VOICE CONTROL SOLN	T1	
INPEN (FOR HUMALOG)	T1	
INPEN (FOR NOVOLOG OR FIASP)	T1	
INSUL-CAP	T1	
INSUL-EZE	T1	
LANCING DEVICE	T1	
LANCING SYSTEM	T1	
LANZO	T1	
LITE TOUCH LANCING PEN	T1	
MEDISENSE	T1	
MEDISENSE GLUCOSE KETONE	T1	
MEDISENSE GLUCOSE KETONE CONTR	T1	
MEDTRONIC REMOTE CONTROL	T1	
MICRODOT HIGH-LOW CONTROL SOL	T1	
MICRODOT NORMAL CONTROL SOLUT	T1	
MICROLET 2	T1	
MICROLET NEXT LANCING DEVICE	T1	
MINI LANCING DEVICE	T1	
MINIMED QUICK-SERTER	T1	
MULTI-LANCET	T1	
MYGLUCOHEALTH CONTROL SOLUTION	T1	
NOVA MAX PLUS GLUC-KETON METER	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
NOVAMAX PLUS GLU-KET	T1	
NOVOPEN ECHO	T1	
OMNIPOD 5 (G6/LIBRE 2 PLUS)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD 5 DEXG7G6 INTRO(GEN 5)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD 5 INTRO(G6/LIBRE2PLUS)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD CLASSIC PDM KIT(GEN 3)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD CLASSIC PODS (GEN 3)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD DASH INTRO KIT (GEN 4)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD DASH PODS (GEN 4)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD GO PODS	T2	QL(30 CRTGS/30 DAYS)
ON CALL EXPRESS CONTROL SOLN	T1	
ON CALL LANCING DEVICE	T1	
ON CALL PLUS CONTROL	T1	
ON CALL PLUS LANCING DEVICE	T1	
ON CALL VIVID CONTROL	T1	
ONETOUCH DELICA PLUS LANC DEV	T1	
ONETOUCH ULTRA CONTROL SOLN	T1	
ONETOUCH VERIO HIGH CNTRL SOLN	T1	
ONETOUCH VERIO MID CNTRL SOLN	T1	
OPTUMRX GLUCOSE CONTROL SOLN	T1	
OVAL TAPE	T1	
PIP GLUCOSE CONTROL SOLUTION	T1	
PRECISION XTRA KETONE-GLUCOSE	T3	
PRODIGY CONTROL SOLUTION	T1	
PRODIGY LANCING DEVICE	T1	
REFUAH PLUS GLUCOSE CONTROL	T1	
RELIAMED MINI LANCING DEVICE	T1	
RIGHTEST CONTROL SOLUTION	T1	
RIGHTEST GD500	T1	
SAFE-CLIP	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
SIL-SERTER	T1	
SMARTDIABETES VANTAGE	T1	
SMARTEST	T1	
SOLUS V2 CONTROL SOLUTION	T1	
SOLUS V2 LANCING DEVICE	T1	
SURE COMFORT LANCING PEN	T1	
SUREFLEX	T1	
SURE-PEN	T1	
SURE-TEST EASYPLUS MINI SOLN	T1	
TELCARE CONTROL SOLUTION	T1	
TRUE METRIX	T1	
TRUECONTROL	T1	
TRUEDRAW	T1	
TWIIST REFILL KT(CSST-NDL-SYR)	T2	QL(30 KITS/30 DAYS)
TWIIST RFL(INFUS-CSST-NDL-SYR)	T2	QL(30 KITS/30 DAYS)
TWIIST STARTER KIT	T2	QL(1 KIT/365 DAYS)
ULTI-LANCE	T1	
ULTRATRAK CONTROL SOL NORMAL	T1	
ULTRATRAK CONTROL SOLUTION	T1	
ULTRATRAK ULTIMATE CNTRL SOLN	T1	
UNISTIK 2	T1	
UNISTRIP	T1	
V-GO 20	T2	
V-GO 30	T2	
V-GO 40	T2	
VIVAGUARD INO CONTROL SOLUTION	T1	
VIVAGUARD LANCING DEVICE	T1	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK FASTCLIX LANCET DRUM	T1	
ACCU-CHEK SAFE-T-PRO	T1	
ACCU-CHEK SAFE-T-PRO PLUS	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) *(cont.)*		
ACCU-CHEK SOFTCLIX	T1	
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE LANCET	T1	
ADVOCATE LANCETS	T1	
ADVOCATE SAFETY LANCET	T1	
AGAMATRIX ULTRA-THIN LANCET	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BLOOD LANCETS	T1	
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARESENS LANCET	T1	
CARETOUCH SAFETY LANCETS	T1	
CARETOUCH TWIST LANCET	T1	
CHOSEN LANCET	T1	
CHOSEN SAFETY LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	
COMFORT EZ	T1	
COMFORT LANCETS	T1	
COMFORT TOUCH PLUS SAFETY LANC	T1	
COMFORT TOUCH ULT THIN LANCET	T1	
DROPLET LANCETS	T1	
DROPSAFE ACTI-LANCE	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH PULL-TOP 26G LANCET	T1	
EASY TOUCH PULL-TOP 28G LANCET	T1	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) *(cont.)*		
EASY TOUCH PULL-TOP 30G LANCET	T1	
EASY TOUCH PULL-TOP 32G LANCET	T1	
EASY TOUCH SAFETY 21G LANCETS	T1	
EASY TOUCH SAFETY 23G LANCETS	T1	
EASY TOUCH SAFETY 26G LANCETS	T1	
EASY TOUCH SAFETY 28G LANCETS	T1	
EASY TOUCH SAFETY 30G LANCETS	T1	
EASY TOUCH SAFETY 32G LANCETS	T1	
EASY TOUCH TWIST 26G LANCETS	T1	
EASY TOUCH TWIST 28G LANCETS	T1	
EASY TOUCH TWIST 30G LANCETS	T1	
EASY TOUCH TWIST 32G LANCETS	T1	
EASY TOUCH TWIST 33G LANCETS	T1	
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS	T1	
EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINGERSTIX	T1	
FONDCIRCLE LANCET	T1	
FORA LANCETS	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
lancets	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) *(cont.)*		
LANCETS	T1	
LITE TOUCH 28G LANCETS	T1	
LITE TOUCH 30G LANCETS	T1	
LITE TOUCH 33G LANCETS	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MICRO THIN LANCET	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS	T1	
MONOLET THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET	T1	
ON CALL PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA SAFETY LANCET	T1	
ONETOUCH LANCETS	T1	
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	
PERFECT POINT SAFETY LANCETS	T1	
PIP LANCET	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCET	T1	
PRO COMFORT LANCETS	T1	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY LANCETS	T1	
PRODIGY TWIST TOP LANCET	T1	
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) *(cont.)*		
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCE SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RIGHTEST GL300 LANCETS	T1	
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTEST LANCET	T1	
SOLUS V2	T1	
SOLUS V2 LANCETS	T1	
STERILANCE TL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TELCARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL 1 LANCET	T1	
TOPCARE UNIVERSAL 1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) *(cont.)*		
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCET	T1	
ULTRA THIN LANCETS	T1	
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II 28G LANCETS	T1	
ULTRA-THIN II 30G LANCETS	T1	
ULTRATLC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	
UNILET EXCELITE II	T1	
UNILET GP LANCET	T1	
UNILET LANCET	T1	
UNILET LANCETS	T1	
UNISTIK 2 COMFORT	T1	
UNISTIK 2 EXTRA	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 DUAL	T1	
UNISTIK 3 EXTRA	T1	
UNISTIK 3 NORMAL	T1	
UNISTIK COMFORT	T1	
UNISTIK CZT	T1	
UNISTIK EXTRA	T1	
UNISTIK NORMAL	T1	
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) *(cont.)*		
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
VIVAGUARD SAFETY LANCET	T1	
NEEDLES/NEEDLELESS DEVICES		
AUTOSHIELD DUO PEN NEEDLE	T1	
BLUNT NEEDLE	T1	
CAREPOINT PRECISION NEEDLE	T1	
CARETOUCH HYPODERMIC NEEDLE	T1	
DROPSAFE SICURA SAFETY NEEDLE	T1	
EASY TOUCH FLIPLOCK NEEDLE	T1	
EASY TOUCH FLIPLOCK NEEDLES	T1	
EASY TOUCH HYPODERMIC NEEDLE	T1	
EASYPOINT NEEDLE	T1	
ECLIPSE NEEDLE	T1	
EXEL HUBER NEEDLE	T1	
EXEL HYPODERMIC NEEDLE	T1	
EXEL MTI DRAWING NEEDLE	T1	
FILTER ASPIRATOR NEEDLE	T1	
FILTER NEEDLE	T1	
FLOW-EZE	T1	
HYPODERMIC NEEDLE	T1	
INTEGRA NEEDLE	T1	
INTEGRA PRECISIONGLIDE NEEDLE	T1	
LIFESHIELD BLUNT CANNULA	T1	
MONOJECT BLOOD COLLECTION	T1	
MONOJECT FILTER NEEDLE	T1	
NANO 2ND GEN PEN NEEDLE	T1	
NANO PEN NEEDLE	T1	
NEEDLE	T1	
NEEDLES	T1	
needles,safety huber,disposabl	T1	
NOKOR ADMIX NEEDLE	T1	
NOKOR NEEDLE	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NEEDLES/NEEDLELESS DEVICES *(cont.)*		
PERFECT POINT SAFETY NEEDLE	T1	
PHASEAL PROTECTOR	T1	
POLY HUB NEEDLE	T1	
PRECISIONGLIDE	T1	
PRECISIONGLIDE NEEDLE	T1	
REGULAR BEVEL NEEDLES	T1	
SAFETYGLIDE NEEDLE	T1	
SHORT BEVEL NEEDLES	T1	
SPECIALTY USE NEEDLES	T1	
TERUMO SURGUARD2	T1	
THIN WALL NEEDLES	T1	
TRANSFER NEEDLE	T1	
ULTRA-FINE MICRO PEN NEEDLE	T1	
ULTRA-FINE MINI PEN NEEDLE	T1	
ULTRA-FINE NANO PEN NEEDLE	T1	
ULTRA-FINE ORIGINAL PEN NEEDLE	T1	
ULTRA-FINE PEN NEEDLE	T1	
ULTRA-FINE SHORT PEN NEEDLE	T1	
YALE NEEDLES	T1	
SYRINGES AND ACCESSORIES		
BD INS SYR 0.3 ML 8MMX31G(1/2)	T1	
BD INS SYR UF 0.3ML 12.7MMX30G	T1	
BD INS SYR UF 0.5ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 30G 12.7MM	T1	
BD INS SYRNG 0.3 ML 29GX12.7MM	T1	
BD INS SYRNG 0.5 ML 29GX12.7MM	T1	
BD INS SYRNG UF 0.3 ML 8MMX31G	T1	
BD INS SYRNG UF 0.5 ML 8MMX31G	T1	
BD INSULIN SYR 0.5 ML 28GX1/2"	T1	
BD INSULIN SYR 1 ML 27GX12.7MM	T1	
BD INSULIN SYR 1 ML 27GX5/8"	T1	
BD INSULIN SYR 1 ML 28GX1/2"	T1	
BD INSULIN SYR 1 ML 29GX12.7MM	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES *(cont.)*		
BD INSULIN SYR UF 1 ML 8MMX31G	T1	
ECLIPSE SYRINGE	T1	
INSULIN SYR 0.5 ML 28G 12.7MM	T1	
INSULIN SYRINGE 1 ML 27G 16MM	T1	
BD INSULIN SYRINGE 1 ML	T1	
INSULIN SYRINGE 1ML 28G 12.7MM	T1	
INSULIN SYRINGE U-500	T1	
MINIMED RESERVOIR	T1	
PARADIGM	T1	
SAFETYGLIDE INSULIN SYRINGE	T1	
SAFETYGLIDE SYRINGE	T1	
ULTRA-FINE INSULIN SYRINGE	T1	
VEO INSULIN SYRINGE	T1	
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous)		
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I)		
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK FASTCLIX LANCET DRUM	T1	
ACCU-CHEK SAFE-T-PRO	T1	
ACCU-CHEK SAFE-T-PRO PLUS	T1	
ACCU-CHEK SOFTCLIX	T1	
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE LANCET	T1	
ADVOCATE LANCETS	T1	
ADVOCATE SAFETY LANCET	T1	
AGAMATRIX ULTRA-THIN LANCET	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BLOOD LANCETS	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) *(cont.)*		
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARESENS LANCET	T1	
CARETOUCH SAFETY LANCETS	T1	
CARETOUCH TWIST LANCET	T1	
CHOSEN LANCET	T1	
CHOSEN SAFETY LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	
COMFORT EZ	T1	
COMFORT LANCETS	T1	
COMFORT TOUCH PLUS SAFETY LANC	T1	
COMFORT TOUCH ULT THIN LANCET	T1	
DROPLET LANCETS	T1	
DROPSAFE ACTI-LANCE	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH PULL-TOP 26G LANCET	T1	
EASY TOUCH PULL-TOP 28G LANCET	T1	
EASY TOUCH PULL-TOP 30G LANCET	T1	
EASY TOUCH PULL-TOP 32G LANCET	T1	
EASY TOUCH SAFETY 21G LANCETS	T1	
EASY TOUCH SAFETY 23G LANCETS	T1	
EASY TOUCH SAFETY 26G LANCETS	T1	
EASY TOUCH SAFETY 28G LANCETS	T1	
EASY TOUCH SAFETY 30G LANCETS	T1	
EASY TOUCH SAFETY 32G LANCETS	T1	
EASY TOUCH TWIST 26G LANCETS	T1	
EASY TOUCH TWIST 28G LANCETS	T1	
EASY TOUCH TWIST 30G LANCETS	T1	
EASY TOUCH TWIST 32G LANCETS	T1	
EASY TOUCH TWIST 33G LANCETS	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) *(cont.)*		
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS	T1	
EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINGERSTIX	T1	
FONDCIRCLE LANCET	T1	
FORA LANCETS	T1	
FORA V10-V12-D10-D20 STRP-LNCT	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	
GOJJI LANCET-GLUCOSE TEST STRP	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
lancets	T1	
LANCETS	T1	
LITE TOUCH 28G LANCETS	T1	
LITE TOUCH 30G LANCETS	T1	
LITE TOUCH 33G LANCETS	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MEDLANCE PLUS SPECIAL BLADE	T1	
MICRO THIN LANCET	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) *(cont.)*		
MICROTAINER LANCETS	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS	T1	
MONOLET THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET	T1	
ON CALL PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA SAFETY LANCET	T1	
ONETOUCH LANCETS	T1	
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	
PERFECT POINT SAFETY LANCETS	T1	
PIP LANCET	T1	
POGO AUTOMATIC TEST CARTRIDGE	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCET	T1	
PRO COMFORT LANCETS	T1	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY LANCETS	T1	
PRODIGY TWIST TOP LANCET	T1	
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCE SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RIGHTEST GL300 LANCETS	T1	
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) *(cont.)*		
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTEST LANCET	T1	
SOLUS V2	T1	
SOLUS V2 LANCETS	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TELCARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL 1 LANCET	T1	
TOPCARE UNIVERSAL 1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCET	T1	
ULTRA THIN LANCETS	T1	
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II 28G LANCETS	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) *(cont.)*		
ULTRA-THIN II 30G LANCETS	T1	
ULTRATLC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	
UNILET EXCELITE II	T1	
UNILET GP LANCET	T1	
UNILET LANCET	T1	
UNILET LANCETS	T1	
UNISTIK 2 COMFORT	T1	
UNISTIK 2 EXTRA	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 DUAL	T1	
UNISTIK 3 EXTRA	T1	
UNISTIK 3 NORMAL	T1	
UNISTIK COMFORT	T1	
UNISTIK CZT	T1	
UNISTIK EXTRA	T1	
UNISTIK NORMAL	T1	
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
VIVAGUARD SAFETY LANCET	T1	
MEDICAL SUPPLIES,MISCELLANEOUS		
ALCOH-GLOVE	T1	
ALCOH-WIPE	T1	
RESPIRATORY AIDS, DEVICES, EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER MECHANICAL VENT	T2	QL(1 SPACER/365 DAYS)

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
RESPIRATORY AIDS, DEVICES, EQUIPMENT *(cont.)*		
AEROCHAMBER MINI	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER MV	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER PLUS FLOW-VU	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER Z-STAT PLUS	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER2GO	T2	QL(1 SPACER/365 DAYS)
AEROTRACH PLUS	T2	QL(1 SPACER/365 DAYS)
AEROVENT PLUS	T2	QL(1 SPACER/365 DAYS)
BREATHERITE	T2	QL(1 SPACER/365 DAYS)
BREATHERITE SPACER-ADULT MASK	T2	QL(1 SPACER/365 DAYS)
BREATHERITE SPACER-INFANT MASK	T2	QL(1 SPACER/365 DAYS)
BREATHERITE SPACER-LG CHLD MSK	T2	QL(1 SPACER/365 DAYS)
BREATHERITE SPACER-NEONATE MSK	T2	QL(1 SPACER/365 DAYS)
BREATHERITE SPACER-SM CHLD MSK	T2	QL(1 SPACER/365 DAYS)
BREATHRITE	T2	QL(1 SPACER/365 DAYS)
CLEVER CHOICE HOLDING CHAMBER	T2	QL(1 SPACER/365 DAYS)
COMFORTSEAL	T2	QL(1 UNIT/365 DAYS)
COMPACT SPACE CHAMBER	T2	QL(1 SPACER/365 DAYS)
EASIVENT HOLDING CHAMBER	T2	QL(1 SPACER/365 DAYS)
EASIVENT MASK-LARGE	T2	QL(1 UNIT/365 DAYS)
EASIVENT MASK-MEDIUM	T2	QL(1 UNIT/365 DAYS)
EASIVENT MASK-SMALL	T2	QL(1 UNIT/365 DAYS)
FLEXICHAMBER	T2	QL(1 SPACER/365 DAYS)
FLEXICHAMBER MASK	T2	QL(1 UNIT/365 DAYS)
LITEAIRE	T2	QL(1 SPACER/365 DAYS)
LITETOUCH	T2	QL(1 UNIT/365 DAYS)
MICROCHAMBER	T2	QL(1 SPACER/365 DAYS)
MICROSPACER	T2	QL(1 SPACER/365 DAYS)
MOUTHPIECE	T2	
ONE WAY MOUTHPIECE	T2	
OPTICHAMBER	T2	QL(1 UNIT/365 DAYS)
OPTICHAMBER DIAMOND	T2	QL(1 SPACER/365 DAYS)
PANDA MASK	T2	
PEDIATRIC MASK	T2	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
RESPIRATORY AIDS, DEVICES, EQUIPMENT *(cont.)*		
PEDIATRIC PANDA MASK	T2	
POCKET CHAMBER	T2	QL(1 SPACER/365 DAYS)
PRIMEAIRE	T2	QL(1 SPACER/365 DAYS)
PRO COMFORT SPACER-ADULT MASK	T3	QL(1 SPACER/365 DAYS)
PRO COMFORT SPACER-CHILD MASK	T3	QL(1 SPACER/365 DAYS)
PRO COMFORT SPACER-INFANT MASK	T3	
PROCARE SPACER WITH ADULT MASK	T2	QL(1 SPACER/365 DAYS)
PROCARE SPACER WITH CHILD MASK	T2	QL(1 SPACER/365 DAYS)
PROCHAMBER	T2	QL(1 SPACER/365 DAYS)
PURE COMFORT SPACER WITH MASK	T2	QL(1 SPACER/365 DAYS)
RITEFLO	T2	QL(1 SPACER/365 DAYS)
SIDESTREAM PEDIATRIC	T2	
SILICONE MASK-INFANT	T2	QL(1 UNIT/365 DAYS)
SILICONE MASK-PEDIATRIC	T2	
SPACE CHAMBER	T2	QL(1 SPACER/365 DAYS)
SPACE CHAMBER-LARGE MASK	T2	QL(1 SPACER/365 DAYS)
SPACE CHAMBER-MEDIUM MASK	T2	QL(1 SPACER/365 DAYS)
SPACE CHAMBER-SMALL MASK	T2	QL(1 SPACER/365 DAYS)
VORTEX ADULT MASK	T2	
VORTEX HOLDING CHAMBER	T2	QL(1 SPACER/365 DAYS)
VORTEX VHC FROG MASK	T2	QL(1 SPACER/365 DAYS)
VORTEX VHC LADYBUG MASK	T2	QL(1 SPACER/365 DAYS)
VORTEX VHC PEDIATRIC MASK	T2	QL(1 SPACER/365 DAYS)
MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)		
SKELETAL MUSCLE RELAX. TOP IRRITANT COUNTER-IRRIT		
COMFORT PAC-CYCLOBENZAPRINE	T3	
COMFORT PAC-TIZANIDINE	T3	
SKELETAL MUSCLE RELAXANTS		
baclofen 10 mg tablet	T1	HD
baclofen 10 mg/5 ml solution	T1	HD
baclofen 20 mg tablet	T1	HD
baclofen 5 mg tablet	T1	HD
baclofen 5 mg/5 ml solution	T1	HD

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List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SKELETAL MUSCLE RELAXANTS *(cont.)*		
carisoprodol (Soma)	T1	
carisoprodol/aspirin	T1	
chlorzoxazone 500 mg tablet	T3	
cyclobenzaprine hcl	T1	
cyclobenzaprine hcl (Fexmid)	T1	
DANTRIUM *(dantrolene sodium)*	T3	
dantrolene sodium	T1	
dantrolene sodium (Dantrium)	T1	
FEXMID *(cyclobenzaprine hcl)*	T1	
metaxalone 400 mg tablet	T1	
metaxalone 800 mg tablet	T1	
methocarbamol	T3	
methocarbamol 1,000 mg tablet	T3	
methocarbamol 500 mg tablet	T3	
methocarbamol 750 mg tablet	T1	
orphenadrine citrate	T1	
tizanidine hcl 2 mg tablet	T1	
tizanidine hcl 4 mg tablet (Zanaflex)	T1	
ZANAFLEX	T3	
ZANAFLEX *(tizanidine hcl)*	T3	
PRE-NATAL VITAMINS (Nutritional/Dietary)		
PRENATAL VITAMIN PREPARATIONS		
BAL-CARE DHA ESSENTIAL	T3	
CITRANATAL 90 DHA	T3	
CITRANATAL ASSURE	T3	
CITRANATAL DHA	T3	
CITRANATAL HARMONY	T3	
CITRANATAL RX	T3	
DERMACINRX PRETRATE	T3	
DUET DHA BALANCED	T3	
KOSHER PRENATAL PLUS IRON	T3	
MARNATAL-F	T3	
mynatal capsule	T3	

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PRE-NATAL VITAMINS (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PRENATAL VITAMIN PREPARATIONS *(cont.)*		
mynatal ultracaplet	T1	
NATACHEW	T3	
NEONATAL COMPLETE	T3	
NEONATAL PLUS	T3	
NEONATAL-DHA	T3	
NESTABS	T2	
NESTABS ABC	T2	
NESTABS DHA	T2	
OB COMPLETE ONE	T2	
OB COMPLETE PETITE	T2	
OB COMPLETE PREMIER	T2	
OB COMPLETE WITH DHA	T2	
OBSTETRIX EC	T3	
OBTREX DHA	T3	
pnv 11/iron fum/folic acid/om3	T1	
pnv 119/iron fum/folic acid	T1	
pnv 66/iron/folic/docusate/dha	T1	
pnv 69/iron/folic/docusate/dha	T1	
pnv 80/iron fum/folic/dss/dha	T1	
pnv no.118/iron fumarate/fa	T1	
pnv no.154/iron fum/folic acid	T1	
pnv no.52/iron/fa/omega-3/dha	T1	
pnv,calcium 72/iron,carb/folic	T1	
pnv,calcium 72/iron/folic acid	T1	
pnv19/iron bg,s.p/folic ac/om3	T1	
pnv81/iron ps,edta/folic/omeg3	T1	
PRENATA	T3	
prenatal 105/iron/folic ac/dha	T1	
prenatal 12/iron/folic/dss/om3	T1	
PRENATAL 19	T1	
prenatal 53/iron/folic ac/omg3	T1	
prenatal 54/iron/folic ac/omg3	T1	
prenatal 71/iron/folic ac/dha	T1	

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PRE-NATAL VITAMINS (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PRENATAL VITAMIN PREPARATIONS *(cont.)*		
prenatal 93/iron/folate 9/dha	T1	
prenatal no.42/folic acid (Vitamedmd Redichew Rx)	T3	
PRENATAL PLUS VITAMIN-MINERAL	T2	
PRENATAL PLUS-DHA	T1	
prenatal vit 27,calc/iron/fa	T1	
prenatal vit 55/iron/folic/om3	T1	
prenatal vit,cal 73/iron/folic	T3	
prenatal vit,cal 76/iron/folic	T3	
prenatal vit,cal 78/iron/folic	T3	
prenatal vit/iron fum/folic ac	T1	
prenatal vits 86/iron/folic ac	T1	
prenatal,calc 40/iron/folate 1	T1	
PRENATE ENHANCE	T3	
PRENATE RESTORE	T3	
PRIMACARE	T3	
PROVIDA OB	T3	
SELECT-OB	T3	
SELECT-OB *(prenatal vit 128/iron/folic ac)*	T3	
SELECT-OB + DHA	T3	
THRIVITE RX	T1	
TRICARE	T3	
TRISTART DHA	T3	
VITAFOL FE PLUS	T3	
VITAFOL NANO	T3	
VITAFOL ULTRA	T3	
VITAFOL-OB	T1	
VITAFOL-OB+DHA	T3	
VITAFOL-ONE	T3	
VITAMEDMD ONE RX	T3	
VITAMEDMD REDICHEW RX *(prenatal no.42/folic acid)*	T3	
VITAPEARL	T3	
VITATRUE	T3	

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PRE-NATAL VITAMINS (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PRENATAL VITAMINS WITH LOW OR NO IRON		
CITRANATAL B-CALM	T3	
DUET DHA 400	T3	
PRENATE DHA	T3	
PRENATE ELITE	T3	
PRENATE MINI	T3	
PRENATE PIXIE	T3	
PRENATE STAR	T3	
R-NATAL OB	T1	
VITAFOL GUMMIES	T3	
PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[10]		
ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS		
mirtazapine	T1	HD
mirtazapine (Remeron)	T1	HD
ANTI-ANXIETY - BENZODIAZEPINES		
alprazolam	T1	
alprazolam (Xanax Xr)	T1	
alprazolam (Xanax)	T1	
chlordiazepoxide hcl	T1	
clorazepate dipotassium	T1	
diazepam 10 mg tablet (Valium)	T1	
diazepam 2 mg tablet (Valium)	T1	
diazepam 25 mg/5 ml oral conc	T1	
diazepam 5 mg tablet (Valium)	T1	
diazepam 5 mg/5 ml oral cup	T1	
lorazepam	T1	
diazepam 5 mg/5 ml solution	T1	
diazepam 5 mg/ml oral conc	T1	
lorazepam	T1	
lorazepam (Ativan)	T1	
oxazepam	T1	
ANTI-ANXIETY DRUGS		
buspirone hcl	T1	HD
meprobamate	T1	

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T3	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 25 MG CAPSULE	T3	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 30 MG CAPSULE	T3	PA QL(14 CAPS/270 DAYS) SP HD
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
lithium carbonate	T1	HD
lithium carbonate (Lithobid)	T1	HD
lithium citrate	T1	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS		
MARPLAN	T3	QL(12 TABS/DAY)
phenelzine sulfate (Nardil)	T1	
tranylcypromine sulfate (Parnate)	T1	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS		
EMSAM 12 MG/24 HOURS PATCH	T3	QL(1 PATCH/DAY)
EMSAM 6 MG/24 HOURS PATCH	T3	QL(2 PATCHES/DAY)
EMSAM 9 MG/24 HOURS PATCH	T3	QL(1 PATCH/DAY)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)		
bupropion hcl 100 mg tablet	T1	QL(4 TABS/DAY) HD
bupropion hcl 75 mg tablet	T1	QL(6 TABS/DAY) HD
bupropion hcl sr 100 mg tablet (Wellbutrin Sr)	T1	QL(4 TABS/DAY) HD
bupropion hcl sr 150 mg tablet (Wellbutrin Sr)	T1	QL(2 TABS/DAY) HD
bupropion hcl sr 200 mg tablet (Wellbutrin Sr)	T1	QL(2 TABS/DAY) HD
bupropion hcl xl 150 mg tablet (Wellbutrin XI)	T1	QL(3 TABS/DAY) HD
bupropion hcl xl 300 mg tablet (Wellbutrin XI)	T1	QL(1 TAB/DAY) HD
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIAs)		
NUPLAZID	T3	PA SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
citalopram hbr 10 mg tablet (Celexa)	T1	QL(6 TABS/DAY) HD
citalopram hbr 10 mg/5 ml soln	T1	QL(30 MLS/DAY) HD
citalopram hbr 20 mg tablet (Celexa)	T1	QL(3 TABS/DAY) HD
citalopram hbr 20 mg/10 ml cup	T1	QL(30 MLS/DAY) HD
citalopram hbr 40 mg tablet (Celexa)	T1	QL(1 TAB/DAY) HD

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) *(cont.)*		
escitalopram 10 mg tablet (Lexapro)	T1	QL(2 TABS/DAY) HD
escitalopram 10 mg/10 ml cup	T1	QL(20 MLS/DAY) HD
escitalopram 20 mg tablet (Lexapro)	T1	QL(1 TAB/DAY) HD
escitalopram 5 mg tablet (Lexapro)	T1	QL(4 TABS/DAY) HD
escitalopram oxalate 5 mg/5 ml	T1	QL(20 MLS/DAY) HD
fluoxetine 20 mg/5 ml soln cup	T1	QL(20 MLS/DAY) HD
fluoxetine 20 mg/5 ml solution	T1	QL(20 MLS/DAY) HD
fluoxetine hcl	T1	QL(4 CAPS/28 DAYS) HD
fluoxetine hcl 10 mg capsule (Prozac)	T1	QL(8 CAPS/DAY) HD
fluoxetine hcl 10 mg tablet	T1	HD
fluoxetine hcl 20 mg capsule (Prozac)	T1	QL(4 CAPS/DAY) HD
fluoxetine hcl 20 mg tablet	T1	HD
fluoxetine hcl 40 mg capsule (Prozac)	T1	QL(2 CAPS/DAY) HD
fluoxetine hcl 60 mg tablet	T1	QL(1 TAB/DAY) HD
fluvoxamine er 100 mg capsule	T1	QL(3 CAPS/DAY) HD
fluvoxamine er 150 mg capsule	T1	QL(2 CAPS/DAY) HD
fluvoxamine maleate 100 mg tab	T1	QL(3 TABS/DAY) HD
fluvoxamine maleate 25 mg tab	T1	QL(12 TABS/DAY) HD
fluvoxamine maleate 50 mg tab	T1	QL(6 TABS/DAY) HD
paroxetine cr 12.5 mg tablet (Paxil Cr)	T1	QL(1 TAB/DAY) HD
paroxetine cr 25 mg tablet (Paxil Cr)	T1	QL(3 TABS/DAY) HD
paroxetine cr 37.5 mg tablet (Paxil Cr)	T1	QL(2 TABS/DAY) HD
paroxetine er 12.5 mg tablet (Paxil Cr)	T1	QL(1 TAB/DAY) HD
paroxetine er 25 mg tablet (Paxil Cr)	T1	QL(3 TABS/DAY) HD
paroxetine er 37.5 mg tablet (Paxil Cr)	T1	QL(2 TABS/DAY) HD
paroxetine hcl 10 mg tablet (Paxil)	T1	QL(6 TABS/DAY) HD
paroxetine hcl 10 mg/5 ml susp	T1	QL(30 MLS/DAY) HD
paroxetine hcl 20 mg tablet (Paxil)	T1	QL(3 TABS/DAY) HD
paroxetine hcl 30 mg tablet (Paxil)	T1	QL(2 TABS/DAY) HD
paroxetine hcl 40 mg tablet (Paxil)	T1	QL(1 TAB/DAY) HD
sertraline 150 mg capsule	T1	QL(1 CAP/DAY) HD
sertraline 20 mg/ml oral conc (Zoloft)	T1	QL(10 MLS/DAY) HD
sertraline 200 mg capsule	T1	QL(1 CAP/DAY) HD
sertraline hcl 100 mg tablet (Zoloft)	T1	QL(2 TABS/DAY) HD

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) *(cont.)*		
sertraline hcl 25 mg tablet (Zoloft)	T1	QL(8 TABS/DAY) HD
sertraline hcl 50 mg tablet (Zoloft)	T1	QL(4 TABS/DAY) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)		
nefazodone hcl	T1	HD
trazodone hcl	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)		
desvenlafaxine succnt er 100mg (Pristiq)	T1	QL(4 TABS/DAY) HD
desvenlafaxine succnt er 25 mg (Pristiq)	T1	QL(16 TABS/DAY) HD
desvenlafaxine succnt er 50 mg (Pristiq)	T1	QL(1 TAB/DAY) HD
duloxetine hcl dr 20 mg cap (Cymbalta)	T1	QL(6 CAPS/DAY) HD
duloxetine hcl dr 30 mg cap (Cymbalta)	T1	QL(4 CAPS/DAY) HD
duloxetine hcl dr 40 mg cap	T1	QL(3 CAPS/DAY) HD
duloxetine hcl dr 60 mg cap (Cymbalta)	T1	QL(2 CAPS/DAY) HD
venlafaxine hcl 100 mg tablet	T1	QL(3 TABS/DAY) HD
venlafaxine hcl 25 mg tablet	T1	QL(15 TABS/DAY) HD
venlafaxine hcl 37.5 mg tablet	T1	QL(10 TABS/DAY) HD
venlafaxine hcl 50 mg tablet	T1	QL(7 TABS/DAY) HD
venlafaxine hcl 75 mg tablet	T1	QL(5 TABS/DAY) HD
venlafaxine hcl er 150 mg cap (Effexor Xr)	T1	QL(2 CAPS/DAY) HD
venlafaxine hcl er 150 mg tab	T1	QL(2 TABS/DAY) HD
venlafaxine hcl er 225 mg tab	T1	QL(1 TAB/DAY) HD
venlafaxine hcl er 37.5 mg cap (Effexor Xr)	T1	QL(8 CAPS/DAY) HD
venlafaxine hcl er 37.5 mg tab	T1	QL(8 TABS/DAY) HD
venlafaxine hcl er 75 mg cap (Effexor Xr)	T1	QL(4 CAPS/DAY) HD
venlafaxine hcl er 75 mg tab	T1	QL(4 TABS/DAY) HD
SSRI AND 5HTIA PARTIAL AGONIST ANTI-DEPRESSANTS		
vilazodone hcl 10 mg tablet (Viibryd)	T1	QL(1 TAB/DAY) HD
vilazodone hcl 20 mg tablet (Viibryd)	T1	QL(1 TAB/DAY) HD
vilazodone hcl 40 mg tablet (Viibryd)	T1	HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS		
TRINTELLIX 10 MG TABLET	T2	QL(1 TAB/DAY)
TRINTELLIX 20 MG TABLET	T2	
TRINTELLIX 5 MG TABLET	T2	QL(1 TAB/DAY)

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS		
amitriptyline/chlordiazepoxide	T1	HD
TRICYCLIC ANTI-DEPRESSANT-PHENOTHIAZINE COMBINATNS		
perphenazine/amitriptyline hcl	T1	HD
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
amitriptyline hcl	T1	HD
amoxapine	T1	HD
clomipramine hcl (Anafranil)	T1	HD
desipramine hcl	T1	HD
doxepin 10 mg capsule	T1	HD
doxepin 10 mg/ml oral conc	T1	HD
doxepin 100 mg capsule	T1	HD
doxepin 150 mg capsule	T1	HD
doxepin 25 mg capsule	T1	HD
doxepin 50 mg capsule	T1	HD
doxepin 75 mg capsule	T1	HD
imipramine hcl	T1	HD
imipramine pamoate	T1	HD
nortriptyline hcl	T1	HD
nortriptyline hcl (Pamelor)	T1	HD
protriptyline hcl	T1	HD
trimipramine maleate	T1	HD
PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[10]		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
lisdexamfetamine 10 mg capsule (Vyvanse)	T1	PA QL(1 CAP/DAY)
lisdexamfetamine 10 mg tb chew (Vyvanse)	T1	PA QL(1 TAB/DAY)
lisdexamfetamine 20 mg capsule (Vyvanse)	T1	PA QL(1 CAP/DAY)
lisdexamfetamine 20 mg tb chew (Vyvanse)	T1	PA QL(1 TAB/DAY)
lisdexamfetamine 30 mg capsule (Vyvanse)	T1	PA QL(1 CAP/DAY)
lisdexamfetamine 30 mg tb chew (Vyvanse)	T1	PA QL(1 TAB/DAY)
lisdexamfetamine 40 mg capsule (Vyvanse)	T1	PA QL(1 CAP/DAY)
lisdexamfetamine 40 mg tb chew (Vyvanse)	T1	PA QL(1 TAB/DAY)
lisdexamfetamine 50 mg capsule (Vyvanse)	T1	PA QL(1 CAP/DAY)
lisdexamfetamine 50 mg tb chew (Vyvanse)	T1	PA QL(1 TAB/DAY)

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PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE *(cont.)*		
lisdexamfetamine 60 mg capsule (Vyvanse)	T1	PA QL(1 CAP/DAY)
lisdexamfetamine 60 mg tb chew (Vyvanse)	T1	PA QL(1 TAB/DAY)
lisdexamfetamine 70 mg capsule (Vyvanse)	T1	PA QL(1 CAP/DAY)
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
clonidine hcl er 0.1 mg tablet (Kapvay)	T1	
guanfacine hcl (Intuniv)	T1	HD
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
DAYTRANA (*methylphenidate*)	T3	PA QL(1 PATCH/DAY)
dexmethylphenidate hcl (Focalin Xr)	T1	PA QL(1 CAP/DAY)
dexmethylphenidate hcl (Focalin)	T1	PA
FOCALIN *(dexmethylphenidate hcl)*	T3	PA ST
METHYLIN *(methylphenidate hcl)*	T3	PA
methylphenidate (Daytrana)	T1	PA QL(1 PATCH/DAY)
methylphenidate er 10 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
methylphenidate er 10 mg tab	T1	PA QL(2 TABS/DAY)
methylphenidate er 15 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
methylphenidate er 18 mg tab (Concerta)	T1	PA QL(1 TAB/DAY)
methylphenidate er 18 mg tab (Relexxii)	T1	PA QL(1 TAB/DAY)
methylphenidate er 20 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
methylphenidate er 20 mg tab	T1	PA QL(3 TABS/DAY)
methylphenidate er 27 mg tab (Concerta)	T1	PA QL(1 TAB/DAY)
methylphenidate er 27 mg tab (Relexxii)	T1	PA QL(1 TAB/DAY)
methylphenidate er 30 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
methylphenidate er 36 mg tab (Concerta)	T1	PA QL(2 TABS/DAY)
methylphenidate er 36 mg tab (Relexxii)	T1	PA QL(2 TABS/DAY)
methylphenidate er 40 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
methylphenidate er 50 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
methylphenidate er 54 mg tab (Concerta)	T1	PA QL(1 TAB/DAY)
methylphenidate er 54 mg tab (Relexxii)	T1	PA QL(1 TAB/DAY)
methylphenidate er 60 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
methylphenidate er 72 mg tab	T1	PA QL(1 TAB/DAY)
methylphenidate er(la) 10mg cp (Ritalin La)	T1	PA QL(1 CAP/DAY)
methylphenidate er(la) 20mg cp (Ritalin La)	T1	PA QL(1 CAP/DAY)

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PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY *(cont.)*		
methylphenidate er(la) 30mg cp (Ritalin La)	T1	PA QL(2 CAPS/DAY)
methylphenidate er(la) 40mg cp (Ritalin La)	T1	PA QL(1 CAP/DAY)
methylphenidate er(la) 60mg cp	T1	PA QL(1 CAP/DAY)
methylphenidate hcl	T1	PA
methylphenidate hcl (Metadate Cd)	T1	PA QL(1 CAP/DAY)
methylphenidate hcl (Methylin)	T1	PA
methylphenidate hcl (Ritalin)	T1	PA
QUILLIVANT XR	T3	PA QL(12 MLS/DAY)
RITALIN *(methylphenidate hcl)*	T3	PA ST
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
atomoxetine hcl 10 mg capsule (Strattera)	T1	HD
atomoxetine hcl 100 mg capsule (Strattera)	T1	HD
atomoxetine hcl 18 mg capsule (Strattera)	T1	HD
atomoxetine hcl 25 mg capsule (Strattera)	T1	HD
atomoxetine hcl 40 mg capsule (Strattera)	T1	QL(1 CAP/DAY) HD
atomoxetine hcl 60 mg capsule (Strattera)	T1	HD
atomoxetine hcl 80 mg capsule (Strattera)	T1	HD
PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[10]		
ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
pimozide	T1	
ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST		
asenapine maleate (Saphris)	T1	
CAPLYTA	T3	ST QL(1 CAP/DAY)
clozapine	T1	
clozapine (Clozaril)	T1	
lurasidone hcl 120 mg tablet (Latuda)	T1	
lurasidone hcl 20 mg tablet (Latuda)	T1	
lurasidone hcl 40 mg tablet (Latuda)	T1	QL(1 TAB/DAY)
lurasidone hcl 60 mg tablet (Latuda)	T1	QL(1 TAB/DAY)
lurasidone hcl 80 mg tablet (Latuda)	T1	
olanzapine	T1	
olanzapine (Zyprexa Zydis)	T1	
olanzapine (Zyprexa)	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST *(cont.)*		
paliperidone er 1.5 mg tablet	T1	
paliperidone er 3 mg tablet (Invega)	T1	QL(1 TAB/DAY)
paliperidone er 6 mg tablet (Invega)	T1	
paliperidone er 9 mg tablet (Invega)	T1	
quetiapine fumarate (Seroquel Xr)	T1	
*quetiapine fumarate 100 mg tab (*Seroquel*)*	T1	
*quetiapine fumarate 200 mg tab (*Seroquel*)*	T1	
*quetiapine fumarate 25 mg tab (*Seroquel*)*	T1	
*quetiapine fumarate 300 mg tab (*Seroquel*)*	T1	
*quetiapine fumarate 400 mg tab (*Seroquel*)*	T1	
*quetiapine fumarate 50 mg tab (*Seroquel*)*	T1	
risperidone	T1	
risperidone (Risperdal)	T1	
SAPHRIS (*asenapine maleate*)	T3	ST
SECUADO	T3	ST
SEROQUEL (*quetiapine fumarate*)	T3	ST
SEROQUEL XR (*quetiapine fumarate*)	T3	ST
ziprasidone hcl (Geodon)	T1	
ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
VRAYLAR 1.5 MG CAPSULE	T3	ST QL(1 CAP/DAY)
VRAYLAR 3 MG CAPSULE	T3	ST QL(1 CAP/DAY)
VRAYLAR 4.5 MG CAPSULE	T3	ST
VRAYLAR 6 MG CAPSULE	T3	ST
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
aripiprazole	T1	
aripiprazole 1 mg/ml solution	T1	
aripiprazole 10 mg tablet (Abilify)	T1	
aripiprazole 15 mg tablet (Abilify)	T1	
aripiprazole 2 mg tablet (Abilify)	T1	
aripiprazole 20 mg tablet (Abilify)	T1	
aripiprazole 30 mg tablet (Abilify)	T1	
aripiprazole 5 mg tablet (Abilify)	T1	QL(1 TAB/DAY)
REXULTI 0.25 MG TABLET	T2	ST QL(1 TAB/DAY)

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED *(cont.)*		
REXULTI 0.5 MG TABLET	T2	ST QL(1 TAB/DAY)
REXULTI 1 MG TABLET	T2	ST QL(1 TAB/DAY)
REXULTI 2 MG TABLET	T2	ST QL(1 TAB/DAY)
REXULTI 3 MG TABLET	T2	ST
REXULTI 4 MG TABLET	T2	ST
ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
loxapine succinate	T1	
ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS, THIOXANTHENES		
thiothixene	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
haloperidol	T1	
haloperidol lactate	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
molindone hcl	T1	
ANTI-PSYCHOTICS, PHENOTHIAZINES		
chlorpromazine hcl	T1	
fluphenazine hcl	T1	
perphenazine	T1	
thioridazine hcl	T1	
trifluoperazine hcl	T1	
SSRI-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG		
olanzapine/fluoxetine hcl	T1	
NEUROACTIVE STEROID GABA-A RECEPTOR MODULATOR		
ZTALMY	T3	PA QL(36 MLS/DAY) SP
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
armodafinil (Nuvigil)	T1	PA
modafinil (Provigil)	T1	PA
SUNOSI	T2	PA QL(1 TAB/DAY)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ	T3	PA QL(1 PACK/DAY) SP HD
LUMRYZ STARTER PACK	T3	PA QL SP HD

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List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT *(cont.)*		
SODIUM OXYBATE 0.5 G/ML SOLN	T3	PA QL(18 MLS/DAY) SP HD
XYWAV	T3	PA QL(18 MLS/DAY) SP HD
BARBITURATES		
phenobarbital	T1	
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ LQ	T3	PA SP HD
ramelteon (Rozerem)	T1	QL(1 TAB/DAY)
tasimelteon (Hetlioz)	T1	PA SP
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
DORAL	T3	
estazolam	T1	
flurazepam hcl	T1	
HALCION (*triazolam*)	T3	
midazolam hcl	T1	
QUAZEPAM	T1	
temazepam (Restoril)	T1	
triazolam	T1	
triazolam (Halcion)	T1	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
DAYVIGO	T2	ST QL(1 TAB/DAY)
doxepin hcl 3 mg tablet (Silenor)	T1	QL(1 TAB/DAY)
doxepin hcl 6 mg tablet (Silenor)	T1	
eszopiclone (Lunesta)	T1	
zaleplon	T1	
zolpidem tart 1.75 mg tab sl	T1	
zolpidem tart 3.5 mg tablet sl	T1	
zolpidem tart er 12.5 mg tab	T1	
zolpidem tart er 6.25 mg tab	T1	QL(1 TAB/DAY)
zolpidem tartrate 10 mg tablet (Ambien)	T1	
zolpidem tartrate 5 mg tablet (Ambien)	T1	

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SKIN PREPS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTISEPTICS,GENERAL		
alcohol antiseptic pads	T1	
ALCOHOL PREP PADS	T1	
ALCOHOL SWAB	T1	
ALCOHOL SWABS	T1	
ALCOHOL WIPES	T1	
CARETOUCH ALCOHOL PREP PAD	T1	
CURITY ALCOHOL PREPS	T1	
DROPSAFE PREP PADS	T1	
EASY COMFORT ALCOHOL PAD	T1	
EASY TOUCH ALCOHOL PREP PADS	T1	
INCONTROL ALCOHOL PADS	T1	
PRO COMFORT ALCOHOL PADS	T1	
PURE COMFORT ALCOHOL PAD	T1	
SINGLE USE SWAB	T1	
SURE COMFORT ALCOHOL	T1	
SURE-PREP ALCOHOL PREP PADS	T1	
TRUE COMFORT ALCOHOL PADS	T1	
TRUE COMFORT PRO ALCOHOL PADS	T1	
ULTILET ALCOHOL SWAB	T1	
WEBCOL	T1	
IRRIGANTS		
acetic acid	T1	
neomycin sulf/polymyxin b sulf	T1	
PHYSIOLYTE *(physiological irrig soln no.1)*	T3	
PHYSIOSOL *(physiological irrig soln no.1)*	T3	
ringer's solution	T1	
ringer's solution, lactated	T1	
sod,pot chlor/mag/sod,pot phos	T3	
sodium chloride 0.9% irrig	T1	
SODIUM CHLORIDE 0.9% IRRIG.	T3	
sodium chloride 0.9% prcss sol	T1	
sodium chloride irrig solution	T1	

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List of Prescription Medications

SKIN PREPS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRRIGANTS *(cont.)*		
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
water for irrigation, sterile	T1	
OXIDIZING AGENTS		
hydrogen peroxide	T1	
SKIN PREPS (Pain Relief And Inflammatory Disease)		
ANTI-PSORIATIC AGENTS, SYSTEMIC		
acitretin	T1	
BIMZELX	T3	PA QL(2 MLS/28 DAYS) SP HD
BIMZELX AUTOINJECTOR	T3	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX (2 SYRINGES)	T3	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX 150 MG/ML SYRINGE	T3	PA QL(1 ML/28 DAYS) SP HD
COSENTYX 75 MG/0.5 ML SYRINGE	T3	PA QL(0.5 MLS/28 DAYS) SP HD
COSENTYX SENSOREADY (2 PENS)	T3	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX SENSOREADY PEN	T3	PA QL(1 ML/28 DAYS) SP HD
COSENTYX UNOREADY PEN	T3	PA QL(2 MLS/28 DAYS) SP HD
ILUMYA	T3	PA QL(1 UNIT/84 DAYS) SP HD
methoxsalen	T1	
SILIQ	T3	PA QL(3 MLS/28 DAYS) SP HD
SKYRIZI	T2	PA QL(150 MG/84 DAYS) SP HD
SKYRIZI PEN	T2	PA QL(150 MG/84 DAYS) SP HD
SOTYKTU	T2	PA QL(1 TAB/DAY) SP HD
SPEVIGO	T3	PA QL(2 MLS/28 DAYS) SP HD
TALTZ AUTOINJECTOR	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ SYRINGE	T2	PA QL(1 SYRINGE/28 DAYS) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
diclofenac sodium 1% gel	T1	QL(1000 GMS/30 DAYS) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ABSORICA (*isotretinoin*)	T3	
isotretinoin (Absorica)	T1	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ACNE AGENTS, TOPICAL		
ACZONE 7.5% GEL PUMP (*dapsone*)	T3	
adapalene/benzoyl peroxide	T1	
adapalene/benzoyl peroxide (Epiduo Forte)	T1	
clindamycin phos/benzoyl perox	T1	
clindamycin phos/benzoyl perox (Acanya)	T1	
clindamycin/tretinoin (Veltin)	T1	
clindamycin/tretinoin (Ziana)	T1	
clindamycin-benzoyl perox 1-5%	T1	
clindamycin-bnz perox 1-5% pmp	T1	
dapsone 5% gel (Aczone)	T1	
dapsone 7.5% gel pump (Aczone)	T1	
KLARON *(sulfacetamide sodium)*	T3	
neuac gel	T1	
ONEXTON *(clindamycin phos/benzoyl perox)*	T3	
sulfacetamide sodium (Klaron)	T1	
TWYNEO	T3	
ANTI-PERSPIRANTS		
DRYSOL	T3	
ANTI-PSORIATICS AGENTS		
anthralin	T1	
calcipotriene 0.005% cream	T1	
CALCIPOTRIENE 0.005% FOAM	T3	
calcipotriene 0.005% ointment	T1	
calcipotriene 0.005% solution	T1	
calcitriol 3 mcg/g ointment (Vectical)	T1	QL(800 GMS/30 DAYS)
tazarotene 0.05% cream (Tazorac)	T1	
tazarotene 0.05% gel (Tazorac)	T1	
tazarotene 0.1% cream (Tazorac)	T1	
tazarotene 0.1% gel (Tazorac)	T1	
TAZORAC *(tazarotene)*	T3	
ANTI-SEBORRHEIC AGENTS		
OVACE PLUS	T3	
selenium sulfide	T1	
sulfacetamide sodium	T1	

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SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTISEPTICS,GENERAL		
alcohol antiseptic pads	T1	
ALCOHOL PREP PADS	T1	
ALCOHOL SWAB	T1	
ALCOHOL SWABS	T1	
ALCOHOL WIPES	T1	
CARETOUCH ALCOHOL PREP PAD	T1	
CURITY ALCOHOL PREPS	T1	
DROPSAFE PREP PADS	T1	
EASY COMFORT ALCOHOL PAD	T1	
EASY TOUCH ALCOHOL PREP PADS	T1	
INCONTROL ALCOHOL PADS	T1	
PRO COMFORT ALCOHOL PADS	T1	
PURE COMFORT ALCOHOL PAD	T1	
SINGLE USE SWAB	T1	
SURE COMFORT ALCOHOL	T1	
SURE-PREP ALCOHOL PREP PADS	T1	
TRUE COMFORT ALCOHOL PADS	T1	
TRUE COMFORT PRO ALCOHOL PADS	T1	
ULTILET ALCOHOL SWAB	T1	
WEBCOL	T1	
ANTISEPTICS, MISCELLANEOUS		
GUAIACOL	T1	
EMOLLIENTS		
ammonium lactate	T1	
HPR PLUS-MB HYDROGEL	T1	
XCLAIR	T3	
IMMUNOMODULATORS		
imiquimod 5% cream packet	T1	
IRRITANTS/COUNTER-IRRITANTS		
methyl salicylate	T1	
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T2	PA QL(30 TABS/30 DAYS) SP

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SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
KERATOLYTICS		
benzepro 6% foaming cloths	T1	
BENZEPRO 7% CREAMY WASH (benzoyl peroxide microspheres)	T3	
benzoyl peroxide	T1	
benzoyl peroxide (Pacnex)	T1	
ENZOCLEAR	T3	
INOVA	T3	
PACNEX *(benzoyl peroxide)*	T3	
podofilox	T1	
podofilox (Condylox)	T1	
PR BENZOYL PEROXIDE *(benzoyl peroxide microspheres)*	T3	
silver nitrate	T1	
PROTECTIVES		
PHARMABASE BARRIER *(zinc oxide)*	T3	
zinc oxide	T1	
ZINC OXIDE	T1	
ROSACEA AGENTS, TOPICAL		
*azelaic acid (*Finacea*)*	T1	
*ivermectin 1% cream (*Soolantra*)*	T1	
metronidazole	T1	
*metronidazole (*Metrocream*)*	T1	
*metronidazole 0.75% cream (*Metrocream*)*	T1	
metronidazole 0.75% lotion	T1	
metronidazole top 1% gel pump	T1	
metronidazole topical 0.75% gl	T1	
*metronidazole topical 1% gel (*Metrogel*)*	T1	
SOOLANTRA (*ivermectin*)	T3	
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
TISSEEL VHSD	T3	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	ST
ZORYVE 0.15% CREAM	T2	ST QL(60 GMS/30 DAYS)

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SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL AGENTS, MISCELLANEOUS		
MEDIHONEY	T3	
trichloroacetic acid	T3	
TRICHLOROACETIC ACID	T3	
TRICHLOROACETIC ACID *(trichloroacetic acid)*	T3	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	
TOPICAL ANTICHOLINERGIC HYPERHIDROSIS TX AGENTS		
QBREXZA	T3	PA
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP *(hydrocortisone)*	T3	ST
alclometasone dipropionate	T1	
amcinonide 0.1% cream	T1	
AQUA GLYCOLIC HC	T3	
betamethasone dipropionate	T1	
betamethasone valerate	T1	
betamethasone/propylene glyc	T1	
betamethasone/propylene glyc (Diprolene)	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
clobetasol 0.05% cream	T1	
clobetasol 0.05% gel	T1	
clobetasol 0.05% ointment (Temovate)	T1	
clobetasol 0.05% shampoo (Clobex)	T1	
clobetasol 0.05% solution	T1	
clobetasol 0.05% topical lotn	T1	
clobetasol prop 0.05% foam (Olux)	T1	
clobetasol prop 0.05% spray (Clobex)	T1	
clobetasol propionate/emoll	T1	
clocortolone pivalate (Cloderm)	T1	
CLODAN 0.05% KIT	T3	ST
clodan 0.05% shampoo (Clobex)	T1	
CLODERM	T3	ST
CLODERM *(clocortolone pivalate)*	T3	ST

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SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL *(cont.)*		
DERMA-SMOOTHE-FS *(fluocinolone acetonide)*	T3	ST
DERMA-SMOOTHE-FS *(fluocinolone/shower cap)*	T3	ST
desonide	T1	
desonide (Tridesilon)	T1	
desoximetasone (Topicort)	T1	
DIPROLENE *(betamethasone/propylene glyc)*	T3	ST
fluocinolone acetonide	T1	
fluocinolone acetonide (Derma-Smoothe-Fs)	T1	
fluocinolone acetonide (Synalar)	T1	
fluocinolone/shower cap (Derma-Smoothe-Fs)	T1	
fluocinonide	T1	
fluocinonide (Vanos)	T1	
fluocinonide/emollient base	T1	
fluticasone prop 0.005% oint	T1	
fluocinolone acetonide	T1	
fluocinolone acetonide (Derma-Smoothe-Fs)	T1	
fluocinolone acetonide (Synalar)	T1	
fluocinolone/shower cap (Derma-Smoothe-Fs)	T1	
fluocinonide	T1	
fluocinonide (Vanos)	T1	
fluocinonide/emollient base	T1	
fluticasone prop 0.005% oint	T1	
fluticasone prop 0.05% cream	T1	
fluticasone prop 0.05% lotion	T1	
fluticasone propionate	T1	
halcinonide 0.1% solution	T1	
halobetasol propionate	T1	
hydrocortisone	T1	
hydrocortisone (Ala-Scalp)	T1	
hydrocortisone (Anusol-Hc)	T1	
hydrocortisone acetate	T1	
hydrocortisone buty 0.1% cream	T1	
hydrocortisone butyr 0.1% oint	T1	

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SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL *(cont.)*		
hydrocortisone butyr 0.1% soln	T1	
hydrocortisone valerate	T1	
mometasone furoate 0.1% cream	T1	
mometasone furoate 0.1% oint	T1	
mometasone furoate 0.1% soln	T1	
NUCORT	T3	ST
prednicarbate	T1	
SCALACORT DK	T3	ST
SYNALAR	T3	ST
SYNALAR *(fluocinolone acetonide)*	T3	ST
SYNALAR TS	T3	ST
TEMOVATE *(clobetasol propionate)*	T3	ST
TEXACORT	T3	ST
TOPICORT *(desoximetasone)*	T3	ST
triamcinolone 0.025% cream	T1	
triamcinolone 0.025% lotion	T1	
triamcinolone 0.025% oint	T1	
triamcinolone 0.1% cream	T1	
triamcinolone 0.1% lotion	T1	
triamcinolone 0.1% ointment	T1	
triamcinolone 0.5% cream	T1	
triamcinolone 0.5% ointment	T1	
triamcinolone acetonide	T1	
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
EPIFOAM	T2	
hydrocortisone/pramoxine	T1	
lidocaine/hydrocortisone ac	T1	
PRAMOSONE	T3	
TOPICAL JANUS KINASE (JAK) INHIBITORS		
OPZELURA	T3	
TOPICAL PREPARATIONS, ANTIBACTERIALS		
iodine/potassium iodide	T1	
iodine/sodium iodide	T1	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL PREPARATIONS, ANTIBACTERIALS *(cont.)*		
IODOFLEX	T3	
IODOSORB	T3	
silver nitrate	T1	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
calcipotriene/betamethasone (Taclonex)	T1	
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T3	QL(60 GMS/30 DAYS)
VITAMIN A DERIVATIVES		
adapalene 0.1% cream (Differin)	T1	PA
ADAPALENE 0.1% LOTION	T1	PA
adapalene 0.1% solution	T1	PA
adapalene 0.3% gel	T1	PA
adapalene 0.3% gel pump (Differin)	T1	PA
RETIN-A MICRO PUMP 0.08% GEL *(tretinoin microspheres)*	T3	PA
tretinoin 0.01% gel (Retin-A)	T1	
tretinoin 0.025% cream (Retin-A)	T1	PA
tretinoin 0.025% gel (Retin-A)	T1	
tretinoin 0.05% cream (Retin-A)	T1	PA
tretinoin 0.05% gel (Atralin)	T1	PA
tretinoin 0.1% cream (Retin-A)	T1	PA
tretinoin microspheres (Retin-A Micro Pump)	T1	PA
tretinoin microspheres (Retin-A Micro)	T1	PA
SMOKING DETERRENTS (Smoking Cessation)[9]		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T3	PPACA
NICOTROL NS	T3	PPACA
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
APO-VARENICLINE 0.5 MG TABLET	T3	
APO-VARENICLINE 1 MG TABLET	T3	
CHANTIX	T3	PA
varenicline 0.5 mg tablet	T1	PPACA
varenicline 1 mg cont month bx	T1	PPACA
varenicline 1 mg tablet	T1	PPACA
varenicline starting month box	T1	PPACA

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SMOKING DETERRENTS (Smoking Cessation)[9] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
bupropion hcl sr 150 mg tablet	T1	PPACA
THYROID PREPS (Hormonal Agents)		
ANTI-THYROID PREPARATIONS		
methimazole	T1	HD
propylthiouracil	T1	HD
THYROID HORMONES		
adthyza 120 mg tablet	T1	HD
adthyza 15 mg tablet	T1	HD
adthyza 30 mg tablet	T1	HD
adthyza 60 mg tablet	T1	HD
adthyza 90 mg tablet	T1	HD
CYTOMEL *(liothyronine sodium)*	T3	HD
levothyroxine 100 mcg tablet (Synthroid)	T1	HD
levothyroxine 112 mcg tablet (Synthroid)	T1	HD
levothyroxine 125 mcg tablet (Synthroid)	T1	HD
levothyroxine 137 mcg tablet (Synthroid)	T1	HD
levothyroxine 150 mcg tablet (Synthroid)	T1	HD
levothyroxine 175 mcg tablet (Synthroid)	T1	HD
levothyroxine 200 mcg tablet (Synthroid)	T1	HD
levothyroxine 25 mcg tablet (Synthroid)	T1	HD
levothyroxine 300 mcg tablet (Synthroid)	T1	HD
levothyroxine 50 mcg tablet (Synthroid)	T1	HD
levothyroxine 75 mcg tablet (Synthroid)	T1	HD
levothyroxine 88 mcg tablet (Synthroid)	T1	HD
levothyroxine sodium (Synthroid)	T1	HD
liothyronine sodium (Cytomel)	T1	HD
thyroid,pork	T1	HD
UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)		
CYTOCHROME P450 INHIBITORS		
TYBOST	T3	SP
CYSTIC FIBROSIS - INHALED OSMOTIC AGENTS		
BRONCHITOL	T3	PA SP HD

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UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ALYFTREK 10-50-125 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD
ALYFTREK 4-20-50 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD
ORKAMBI 100 MG-125 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T3	PA QL(2 PACKS/DAY) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T3	PA QL(2 PACKS/DAY) SP HD
ORKAMBI 200 MG-125 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD
ORKAMBI 75-94 MG GRANULE PKT	T3	PA QL(2 PACKS/DAY) SP HD
SYMDEKO	T3	PA QL(2 TABS/DAY) SP HD
TRIKAFTA 100-50-75 MG/150 MG	T3	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T3	PA QL(2 UNITS/DAY) SP HD
TRIKAFTA 50-25-37.5 MG/75 MG	T3	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T3	PA QL(2 UNITS/DAY) SP HD
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
KALYDECO 13.4 MG GRANULES PKT	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 150 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD
KALYDECO 25 MG GRANULES PACKET	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 5.8 MG GRANULES PKT	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 50 MG GRANULES PACKET	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 75 MG GRANULES PACKET	T3	PA QL(2 PACKS/DAY) SP HD
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T3	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T2	PA SP HD
SYSTEMIC ENZYME INHIBITORS		
JOENJA	T3	PA QL(2 TABS/DAY) SP
VIJOICE 125 MG TABLET	T3	PA QL(1 TAB/DAY) SP
VIJOICE 250 MG DAILY DOSE PACK	T3	PA QL(2 TABS/DAY) SP
VIJOICE 50 MG GRANULE PACKET	T3	PA QL(1 TAB/DAY) SP
VIJOICE 50 MG TABLET	T3	PA QL(1 TAB/DAY) SP
ZOKINVY	T3	PA QL(4 CAPS/DAY) SP

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UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T2	PA QL(1 PEN/28 DAYS) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T2	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T2	PA SP
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant acetate (Firazyr)	T1	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T3	PA SP HD
ORLADEYO	T3	PA QL(1 CAP/DAY) SP
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
leucovorin calcium	T1	CSL
mesna (Mesnex)	T1	SP CSL
MESNEX *(mesna)*	T3	SP CSL
VISTOGARD	T3	SP CSL
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DENTAL AIDS AND PREPARATIONS		
chlorhexidine gluconate (Peridex)	T1	
PERIDEX *(chlorhexidine gluconate)*	T3	
triamcinolone 0.1% paste	T1	
triamcinolone acetonide	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
doxycycline hyclate 20 mg tab	T1	
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
avanafil (Stendra)	T1	QL(8 TABS/30 DAYS)
CAVERJECT	T3	PA QL(6 INJECTIONS/30 DAYS)
CIALIS 10 MG TABLET (*tadalafil*)	T3	ST QL(8 TABS/30 DAYS)
CIALIS 20 MG TABLET (*tadalafil*)	T3	ST QL(8 TABS/30 DAYS)

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UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) *(cont.)*		
CIALIS 5 MG TABLET (*tadalafil*)	T3	ST QL(1 TAB/DAY)
EDEX	T3	PA QL(6 INJECTIONS/30 DAYS)
IFE-BIMIX 30/1	T2	
MUSE	T3	PA QL(6 SUPPS/30 DAYS)
sildenafil 100 mg tablet (Viagra)	T1	QL(8 TABS/30 DAYS) HD
sildenafil 25 mg tablet (Viagra)	T1	QL(8 TABS/30 DAYS) HD
sildenafil 50 mg tablet (Viagra)	T1	QL(8 TABS/30 DAYS) HD
STENDRA *(avanafil)*	T3	ST QL(8 TABS/30 DAYS)
tadalafil 10 mg tablet (Cialis)	T1	QL(8 TABS/30 DAYS) HD
tadalafil 2.5 mg tablet	T1	QL(1 TAB/DAY) HD
tadalafil 20 mg tablet (Cialis)	T1	QL(8 TABS/30 DAYS) HD
tadalafil 5 mg tablet (Cialis)	T1	QL(1 TAB/DAY) HD
vardenafil hcl	T1	QL(8 TABS/30 DAYS)
VIAGRA *(sildenafil citrate)*	T3	ST QL(8 TABS/30 DAYS)
UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)		
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA	T2	QL(8.4 MLS/30 DAYS)
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T3	
ORAMAGICRX	T3	
PPAR AGONIST		
IQIRVO	T2	PA SP HD
SALIVA STIMULANT AGENTS		
NUMOISYN	T3	
THYROID HORMONE RECEPTOR (THR) AGONIST		
REZDIFFRA	T3	PA QL(1 TAB/DAY) SP HD
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T2	PA SP HD

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UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
doxercalciferol	T1	
paricalcitol	T1	SP HD
paricalcitol (Zemplar)	T1	SP HD
RAYALDEE	T3	
ZEMPLAR (*paricalcitol*)	T3	SP HD
MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEP MODULATOR		
OSPHENA	T3	QL(30 TABS/30 DAYS) HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
mifepristone 200 mg tablet	T1	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
dichlorphenamide (Keveyis)	T1	PA SP HD
AMMONIA INHIBITORS		
CARBAGLU *(carglumic acid)*	T3	SP HD
carglumic acid (Carbaglu)	T1	SP HD
ANTI-ALCOHOLIC PREPARATIONS		
acamprosate calcium	T1	
disulfiram	T1	
ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS		
pirfenidone 267 mg capsule	T1	PA SP HD
pirfenidone 267 mg capsule (Esbriet)	T1	PA SP HD
pirfenidone 801 mg capsule (Esbriet)	T1	PA SP HD
CALCIMIMETIC,PARATHYROID CALCIUM ENHANCER		
cinacalcet hcl (Sensipar)	T1	SP
CRYOPRESERVATIVE AGENTS		
dimethyl sulfoxide	T1	
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
nebusal 3% vial	T1	
NEBUSAL 6% VIAL	T3	
sodium chloride 0.9% inhal vl	T1	
sodium chloride 10% vial	T1	

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GENERAL INHALATION AGENTS *(cont.)*		
sodium chloride 3% vial	T1	
sodium chloride 7% vial	T1	
sodium chloride for inhalation	T1	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI	T3	PA SP HD
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
CERDELGA	T2	PA SP HD
miglustat (Zavesca)	T1	PA SP
miglustat (Zavesca)	T1	PA SP HD
OPFOLDA	T3	PA QL(8 CAPS/30 DAYS) SP HD
HYDROXYPHENYL-PYRUVATE DIOXYGENASE(HPPD) INHIBITOR		
nitisinone (Orfadin)	T1	PA SP HD
NITYR	T2	PA SP
ORFADIN	T3	PA SP
ORFADIN *(nitisinone)*	T3	PA SP
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS		
ADDYI	T3	PA QL(1 TAB/DAY)
VYLEESI	T3	PA QL(8 AUTO-INJS/30 DAYS) SP
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs		
paroxetine mesylate	T1	QL(1 CAP/DAY) HD
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T2	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY	T3	PA SP
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T3	
deferasirox (Exjade)	T1	SP HD
deferasirox (Jadenu Sprinkle)	T1	SP HD
deferasirox (Jadenu)	T1	SP HD
deferiprone (Ferriprox (3 Times A Day))	T1	PA SP HD
deferiprone (Ferriprox)	T1	PA SP
EXJADE *(deferasirox)*	T3	PA SP HD
FERRIPROX (2 TIMES A DAY)	T3	PA SP

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
METALLIC POISON, AGENTS TO TREAT *(cont.)*		
FERRIPROX 100 MG/ML SOLUTION	T3	PA SP
GALZIN	T3	SP
RADIOGARDASE	T3	
trientine hcl 250 mg capsule (Syprine)	T1	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T3	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T3	PA SP HD
NEONATAL FC RECEPTOR (FCRN) INHIBITORS		
VYVGART HYTRULO	T3	PA SP HD
OINTMENT/CREAM BASES		
RADIAGEL	T1	
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T3	PA SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
javygtor 100 mg powder packet (Kuvan)	T1	PA SP
javygtor 100 mg tablet (Kuvan)	T1	PA SP HD
javygtor 500 mg powder packet (Kuvan)	T1	PA SP
sapropterin dihydrochloride (Kuvan)	T1	PA SP
sapropterin dihydrochloride (Kuvan)	T1	PA SP HD
PROTEIN STABILIZERS		
ATTRUBY	T3	PA QL(4 TABS/DAY) SP
VYNDAMAX	T3	PA QL(1 CAP/DAY) SP HD
VYNDAQEL	T3	PA QL(4 CAPS/DAY) SP
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS	T3	PA SP
SOLVENTS		
cvs isopropyl alcohol 91%	T1	
CVS ISOPROPYL ALCOHOL 91%	T1	
cvs isopropyl rub alcohol 70%	T1	
CVS ISOPROPYL RUB ALCOHOL 70%	T3	
eql isopropyl alcohol 91%	T1	
eql isopropyl rub alcohol 70%	T1	
FT ISOPROPYL ALCOHOL 91%	T1	

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SOLVENTS *(cont.)*		
FT ISOPROPYL RUB ALCOHOL 70%	T3	
GNP ISOPROPYL ALCOHOL 70%	T3	
GNP ISOPROPYL ALCOHOL 91%	T1	
gnp isopropyl alcohol 99%	T1	
GS ISOPROPYL ALCOHOL 70%	T3	
GS ISOPROPYL ALCOHOL 91%	T1	
hm isopropyl alcohol 70%	T1	
hm isopropyl alcohol 91%	T1	
INSTACLEAN	T1	
ISOPROPANOL	T1	
isopropyl 70% alcohol	T1	
isopropyl alcohol	T1	
isopropyl alcohol 70%	T1	
ISOPROPYL ALCOHOL 70%	T3	
isopropyl alcohol 91%	T1	
isopropyl alcohol 99%	T1	
isopropyl rubbing alcohol 70%	T1	
ISOPROPYL RUBBING ALCOHOL 70%	T3	
ISOPROPYL RUBBING ALCOHOL 91%	T1	
kro isopropyl alcohol 91%	T1	
MURI-LUBE MINERAL OIL	T1	
polyethylene glycol	T1	
ra isopropyl alcohol 70%	T1	
ra isopropyl alcohol 91%	T1	
sm isopropyl alcohol 70%	T1	
swan isopropyl alcohol 70%	T1	
METABOLIC DEFICIENCY AGENTS		
VYKAT XR	T3	PA SP
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
betaine (Cystadane)	T1	SP
CULTURELLE IBS COMPLETE SUPPRT	T3	
CYSTADANE *(betaine)*	T3	SP

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UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
METABOLIC DEFICIENCY AGENTS *(cont.)*		
levocarnitine (Carnitor Sf)	T1	
levocarnitine (Carnitor)	T1	
levocarnitine (with sugar) (Carnitor)	T1	
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
BONE FORMATION STIM. AGENTS- PARATHYROID HORMONE		
*teriparatide (*Bonsity*)*	T1	PA QL(0.09 MLS/DAY) SP HD
*teriparatide (*Forteo*)*	T1	PA QL(0.09 MLS/DAY) SP HD
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T2	ST HD
BONE RESORPTION INHIBITORS		
alendronate sodium	T1	HD
*alendronate sodium (*Fosamax*)*	T1	HD
ATELVIA (*risedronate sodium dr*)	T3	ST HD
BINOSTO	T3	ST HD
FOSAMAX (*alendronate sodium*)	T3	ST HD
ibandronate sodium	T1	HD
raloxifene hcl (Evista)	T1	HD PPACA
risedronate sodium	T1	HD
risedronate sodium (Actonel)	T1	HD
risedronate sodium (Atelvia)	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
ARCALYST	T3	PA SP
ANTI-INFLAMMATORY, INTERLEUKIN-I BETA BLOCKERS		
ILARIS	T3	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA	T3	
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA	T3	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T2	PA SP HD
ADBRY AUTOINJECTOR	T2	PA SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB *(cont.)*		
EBGLYSS PEN	T2	PA SP
EBGLYSS SYRINGE	T2	PA SP
JANUS KINASE (JAK) INHIBITORS		
LEQSELVI	T3	PA QL(2 TABS/DAY) SP HD
LITFULO	T3	PA QL(1 CAP/DAY) SP HD
WOUND HEALING AGENTS, LOCAL		
FILSUVEZ	T3	PA SP
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
lofexidine hcl (Lucemyra)	T1	QL(192 TABS/30 DAYS)
LUCEMYRA (*lofexidine hcl*)	T2	QL(192 TABS/30 DAYS)
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
buprenorphine hcl	T1	
buprenorphine hcl/naloxone hcl	T1	
buprenorphine hcl/naloxone hcl (Suboxone)	T1	
SUBOXONE (*buprenorphine-naloxone*)	T3	
ZUBSOLV	T2	
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
RHO KINASE INHIBITOR		
REZUROCK	T3	PA SP
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
alfuzosin hcl (Uroxatral)	T1	HD
dutasteride (Avodart)	T1	HD
finasteride (Proscar)	T1	HD
silodosin 4 mg capsule (Rapaflo)	T1	QL(1 CAP/DAY) HD
silodosin 8 mg capsule (Rapaflo)	T1	HD
tamsulosin hcl	T1	HD
BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG		
dutasteride/tamsulosin hcl (Jalyn)	T1	HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T2	SP

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ENDOTHELIN RECEPTOR ANTAGONISTS		
VANRAFIA	T2	PA QL(1 TAB/DAY) SP
KIDNEY STONE AGENTS		
tiopronin (Thiola Ec)	T1	SP
tiopronin 100 mg tablet (Thiola)	T1	SP
tiopronin dr 100 mg tablet (Thiola Ec)	T1	SP HD
tiopronin dr 300 mg tablet (Thiola Ec)	T1	SP HD
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEP		
mirabegron er 25 mg tablet (Myrbetriq)	T1	QL(1 TAB/DAY) HD
mirabegron er 50 mg tablet (Myrbetriq)	T1	HD
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.		
darifenacin er 15 mg tablet	T1	HD
darifenacin er 7.5 mg tablet	T1	QL(1 TAB/DAY) HD
solifenacin 10 mg tablet (Vesicare)	T1	HD
solifenacin 5 mg tablet (Vesicare)	T1	QL(1 TAB/DAY) HD
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT		
fesoterodine er 4 mg tablet (Toviaz)	T1	QL(1 TAB/DAY) HD
fesoterodine er 8 mg tablet (Toviaz)	T1	HD
flavoxate hcl	T1	HD
oxybutynin 5 mg tablet	T1	HD
oxybutynin 5 mg/5 ml soln cup	T1	HD
oxybutynin 5 mg/5 ml solution	T1	HD
oxybutynin 5 mg/5 ml syrup	T1	HD
oxybutynin chloride	T1	HD
tolterodine tart er 2 mg cap (Detrol La)	T1	QL(1 CAP/DAY) HD
tolterodine tart er 4 mg cap (Detrol La)	T1	HD
tolterodine tartrate (Detrol)	T1	HD
trospium chloride	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
megestrol 400 mg/10 ml cup	T1	
megestrol 625 mg/5 ml susp	T1	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Weight Management) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND. (cont.)		
megestrol acet 40 mg/ml susp	T1	
megestrol acet 400 mg/10 ml	T1	

VITAMINS (Nutritional/Dietary)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIOXIDANT MULTIVITAMIN COMBINATIONS		
MACUVEX	T2	
MACUZIN	T2	
FOLIC ACID PREPARATIONS		
ENLYTE	T2	
folic acid	T1	
folic acid/b6/ca phos/ginger	T1	
GERIATRIC VITAMIN PREPARATIONS		
REQ49+	T2	
MULTIVITAMIN PREPARATIONS		
ANIMI-3	T2	
BACMIN	T2	
CONCEPT DHA *(mvn-min75/iron/iron ps/om3/dha)*	T3	
CONCEPT OB *(mvn-min 74/iron fum/iron/fa)*	T2	
CORVITE	T2	
DIALYVITE 800 WITH IRON	T2	
ENBRACE HR	T2	
folic/mvi ther-min/lycop/lut	T1	
FORTAVIT	T2	
multivit 47/iron/folate 1/dha	T1	
multivit no.18/iron no.1/folic (Tandem Plus)	T1	
multivit no.51/iron/folic acid	T1	
multivit-min69/iron/folic acid	T1	
multivit-mins no.7/folic acid	T1	
mv-mins 71/iron/folic no.1/dha	T1	
mvn no.53/iron/folic/dss/dha	T1	
mvn-min 74/iron fum/iron/fa (Concept Ob)	T1	
mvn-min75/iron/iron ps/om3/dha (Concept Dha)	T1	

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
NEEVODHA	T2	
NESTABS ONE	T2	
NIVA-PLUS *(multivit-min 60/iron fum/folic)*	T1	
OB COMPLETE	T3	
om-3/dha/epa/b12/fa/b6/phytost	T1	
PRENATE AM	T2	
PRENATE CHEWABLE	T2	
PRENATE ESSENTIAL	T2	
PROTECT IRON	T2	
STROVITE FORTE *(multivit,iron,min 5/folic acid)*	T2	
STROVITE ONE	T2	
TANDEM PLUS *(multivit no.18/iron no.1/folic)*	T3	
UDAMIN SP	T2	
PEDIATRIC VITAMIN PREPARATIONS		
FLORIVA 0.25 MG CHEW TABLET	T2	PPACA
FLORIVA 0.5 MG CHEWABLE TABLET	T2	PPACA
FLORIVA 1 MG CHEWABLE TABLET	T2	PPACA
ped mvit a,c,d3 no.21/fluoride	T1	PPACA
pedi multivit no.12 w-fluoride	T2	PPACA
POLY-VI-FLOR	T2	PPACA
QUFLORA FE	T2	
QUFLORA PED 0.25 MG CHEW TAB	T2	
QUFLORA PED 0.25 MG/ML DROP	T2	PPACA
QUFLORA PED 0.5 MG CHEW TAB	T2	
QUFLORA PED 0.5 MG/ML DROP	T2	PPACA
QUFLORA PED 1 MG CHEW TAB	T2	PPACA
TRI-VI-FLOR	T2	PPACA
VITAMIN B12 PREPARATIONS		
cyanocobalamin (vitamin b-12)	T1	
cyanocobalamin (vitamin b-12) (Nascobal)	T1	
VITAMIN B PREPARATIONS		
b comp no3/folic/c/biotin/zinc	T1	HD
b complex 11/folic/c/biot/zinc	T1	HD

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B PREPARATIONS (cont.)		
cyanocobalamin/folic ac/vit b6	T1	HD
cyanocobalamin/folic ac/vit b6 (Niva-Fol)	T1	HD
DIALYVITE 3000	T2	HD
DIALYVITE 5000	T2	HD
DIALYVITE SUPREME D	T2	HD
folic acid/vit b complex and c	T1	HD
folic acid/vit bcomp,c/cu/zinc	T1	HD
METHAVER	T2	HD
NEPHRON FA	T3	HD
NIVA-FOL (cyanocobalamin/folic ac/vit b6)	T1	HD
VITAL-D RX	T2	HD
VITA-RESPA	T2	HD
VITAMIN D PREPARATIONS		
calcitriol 0.25 mcg capsule	T1	
calcitriol 0.5 mcg capsule	T1	
calcitriol 1 mcg/ml solution (Rocaltrol)	T1	
ergocalciferol (vitamin d2)	T1	HD
VITAMIN K PREPARATIONS		
MEPHYTON *(phytonadione (vit k1))*	T3	
phytonadione (vit k1) (Mephyton)	T1	
VITAMINS (Vitamins)		
MULTIVITAMIN PREPARATIONS		
CITRANATAL MEDLEY	T3	
PEDIATRIC VITAMIN PREPARATIONS		
POLY-VI-FLOR	T2	PPACA
POLY-VI-FLOR WITH IRON	T2	PPACA

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Exclusions and limitations for coverage

Health benefit plans vary, but in general to be eligible for coverage a drug must be approved by the Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and be medically necessary. If your plan provides coverage for certain preventive prescription drugs with no cost-share, you may be required to use an in-network pharmacy to fill the prescription. If you use a pharmacy that does not participate in your plan's network, the prescription may not be covered. Certain drugs may require prior authorization, or be subject to step therapy, quantity limits or other utilization management requirements.

Plans generally do not provide coverage for the following under the pharmacy benefit, except as required by state or federal law, or by the terms of your specific plan:[11]

- Over-the-counter (OTC) medicines (those that do not require a prescription) except insulin unless state or federal law requires coverage of such medicines.
- Prescription medications or supplies for which there is a prescription or OTC therapeutic equivalent or therapeutic alternative.
- Doctor-administered injectable medications covered under the Plan's medical benefit, unless otherwise covered under the Plan's prescription drug list or approved by Cigna Healthcare.
- Implantable contraceptive devices covered under the Plan's medical benefit.
- Medications that are not medically necessary.
- Experimental or investigational medications, including U.S. Food and Drug Administration (FDA)-approved medications used for purposes other than those approved by the FDA unless the medication is recognized for the treatment of the particular indication.
- Medications that are not approved by the FDA.
- Prescription and non-prescription devices, supplies, and appliances other than those supplies specifically listed as covered.
- Medications used for fertility,[12] sexual dysfunction, cosmetic purposes, weight loss, smoking cessation,[12] or athletic enhancement.
- Prescription vitamins (other than prenatal vitamins) or dietary supplements unless state or federal law requires coverage of such products.
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
- Replacement of prescription medications and related supplies due to loss or theft.
- Medications which are to be taken by or administered to a covered person while they are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
- Prescriptions more than one year from the date of issue.
- Coverage for prescription medication products for the amount dispensed (days' supply) which is more than the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which is more than the quantity limit(s) or dosage limit(s) set by the P&T Committee.
- More than one prescription order or refill for a given prescription supply period for the same prescription medication product prescribed by one or more doctors and dispensed by one or more pharmacies.
- Prescription medication products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.

In addition to the plan's standard pharmacy exclusions, certain new FDA-approved medication products (including, but not limited to, medications, medical supplies or devices that are covered under standard pharmacy benefit plans) may not be covered for the first six months of market availability unless approved by Cigna Healthcare as medically necessary.

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Cigna Healthcare reserves the right to make changes to the drug list without notice. Your plan may cover additional medications; please refer to your enrollment materials for details. Cigna Healthcare does not take responsibility for any medication decisions made by the doctor or pharmacist. Cigna Healthcare may receive payments from manufacturers of certain preferred brand medications, and in limited instances, certain non-preferred brand medications, that may or may not be shared with your plan depending on its arrangement with Cigna Healthcare. Depending upon plan design, market conditions, the extent to which manufacturer payments are shared with your plan and other factors as of the date of service, the preferred brand medication may or may not represent the lowest-cost brand medication within its class for you and/or your plan.

Health benefit plans vary, but in general to be eligible for coverage a drug must be approved by the U.S. Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and medically necessary. If your plan provides coverage for certain prescription drugs with no cost-share, you may be required to use an in-network pharmacy to fill the prescription. If you use a pharmacy that does not participate in your plan's network, your prescription may not be covered, or reimbursement may be limited by your plan's copayment, coinsurance or deductible requirements. Certain features described in this document may not be applicable to your specific health plan, and plan features may vary by location and plan type. Refer to your plan documents for costs and complete details of your plan's prescription drug coverage.

1. App/online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
2. Smoking cessation medications are not usually covered under the plan, except as required by law or by the terms of your specific plan. Costs and complete details of the plan's prescription drug coverage, including a full list of exclusions and limitations, are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.
3. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
4. U.S. Food and Drug Administration (FDA) website, "Generic Drug Facts." Content current as of 11/01/21. fda.gov/drugs/generic-drugs/generic-drug-facts.
5. U.S. Food and Drug Administration (FDA) website, "Biosimilar Basics for Patients." Last updated 08/01/24. fda.gov/drugs/biosimilars/biosimilars-basics-patients.
6. **Not all plans offer Express Scripts Pharmacy and Accredo as covered pharmacy options.** Log in to the myCigna App or myCigna.com, or check your plan materials, to learn more about the pharmacies in your plan's network. Cigna Healthcare, Evernorth Health Services, Express Scripts and Accredo are all part of The Cigna Group. This means we have an ownership interest in Express Scripts Pharmacy's home delivery services and Accredo's specialty pharmacy services. However, you have the right to fill prescriptions at any pharmacy in your plan's network (as your plan allows).
7. Your plan pays the cost for standard shipping.
8. Express Scripts Pharmacy can automatically refill certain medications. Log in to the myCigna App or myCigna.com, or call 800.835.3784, to sign up. You can sign up to get emails and/or texts from Express Scripts Pharmacy. To get text messages, you'll have to sign up for the Express Scripts texting service. You can do this online or when you call 800.835.3784 to refill your prescription. Once you sign up, just reply to their welcome text to get started. Standard text messaging rates apply.
9. You can only refill certain specialty medications by text. To get text messages, you'll have to sign up for Accredo's texting service. You can do this when you call Accredo to refill your prescription. Once you sign up, just reply to their welcome text to get started. Standard text messaging rates apply.
10. **For insured plans that must follow Delaware's state insurance laws:** Brand-name antidepressants, smoking cessation, attention deficit hyperactivity disorder (ADHD) and anti-psychotic medications that don't have a generic equivalent available will be covered as Tier 2 (preferred brand). This is true even if the medication is listed as Tier 3 (non-preferred brand) on your plan's drug list. To find out how your specific plans covers these medications, log in to the myCigna App or myCigna.com, or call the number on your ID card.
11. Costs and complete details of the plan's prescription drug coverage are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.
12. **For plans that must follow state insurance laws, such as Delaware:** Your plan may provide coverage for infertility medications and smoking cessation medications even if this drug list states that your plan may not cover them. To find out if your specific plan covers these medications, log in to the myCigna App or myCigna.com, or check your plan materials.

Para obtener ayuda en español llame al número en su tarjeta de Cigna Healthcare.

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Cigna Healthcare® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare does not exclude people or treat them less favorably differently because of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English in a timely manner, such as:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact the Civil Rights Coordinator.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes, you can file a grievance with the Civil Rights Coordinator
P.O. Box 188016, Chattanooga, TN 37422,
877.822.6561 (TTY: Dial 711)

ACAGrievance@CignaHealthcare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at
https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Proficiency of Language Assistance Services

English – ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-244-6224 (TTY: Dial 711) or speak to your provider.

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French – ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont disponibles pour vous. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-244-6224 (TTY : composez le 711) ou parlez à votre fournisseur.

Portuguese – ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-244-6224 (TTY: disque 711) ou fale com seu prestador de serviços.

Polish – UWAGA: Jeśli mówisz po polsku, dostępne są bezpłatne usługi pomocy językowej. Odpowiednie pomoce i usługi wspierające w celu dostarczenia informacji w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-244-6224 (TTY: wybierz 711) lub skontaktuj się ze swoim dostawcą usług.

Japanese – 注意: 日本語を話す場合は、無料の言語支援サービスが利用できます。アクセス可能な形式で情報を提供するための適切な補助機器やサービスも無料で利用できます。1-800-244-6224（TTY: 711 にダイヤル）に電話するか、提供者に話してください。

Italian – ATTENZIONE: Se parli italiano, sono disponibili per te servizi gratuiti di assistenza linguistica. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il numero
1-800-244-6224 (TTY: comporre il 711) o parla con il tuo fornitore.

German – Achtung: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienste, um Informationen in barrierefreien Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-244-6224 an (TTY: Wählen Sie 711) oder sprechen Sie mit Ihrem Anbieter.

Persian (Farsi) - توجه: همچنین، وسایل و خدمات کمکی مناسب برای در دسترس است. خدمات رایگان کمک زبان برای شما صحبت می‌کنید د، اگر به فارسی تماس بگیرید یا با (شماره 711 را بگیرید :TTY) ارائه اطلاعات در قالبهای قابل دسترس به صورت رایگان در دسترس هستند. با شماره 1-800-244-6224 ارائه‌دهنده خود صحبت کنید.